Community mental health policy in the 1990s: a case study in corporate and street level implementation

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A Case Study In Corporate And 'Street Level' Implementation

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To the memory of

Geoffrey 'Tug' Wilson

(1916-1999)

A fine soldier, a great teacher and my first mentor

"Congress may have written the language, but the administrators were doing the translating" (Pressman and Wildavsky, 1984:75)

"What we found, however, is that these very laudable aims are in many cases not being fulfilled nor widely recognised as such by those on the frontline whose job it is to deliver them."

(House of Commons Public Administration Select Committee, 2003:3)

Abstract

This study explores the influence of relationships, attitudes and feelings of clinicians, Community Mental Health Teams (CMHTs) and local management on policy implementation during the first half of 1997 in one mental health trust in London. Drawing upon Sabatier's (1999) analytical recommendations, the theoretical work of a number of policy analysts was utilised. However, Lipsky's (1980) theory of 'street level bureaucracy' and Fisher's work (1998) on decision heuristics were particularly utilised.

A qualitative case study design was employed. National and local policy documents were examined to identify contextual information. A sample of managers (N= 8), local commissioners (N=3) and a number of clinicians from two CMHTs (N= 17) were interviewed and observed in their operationalisation of mental health policy. Four group interviews were held (N=14) to provide further perspectives on the issues of interest. Interview and observational data was transcribed, entered into a qualitative data analysis computer package and analysed utilising the Frameworks Approach (Ritchie and Spencer, 1994).

It was found that a number of managers and clinicians exhibited similar implementation perspectives on policy issues. A number of respondents seemed to employ a set of heuristics that could be organised into an interacting 'economic' and 'risk' schemata. Managers utilised this schemata within a corporate perspective whilst a number of clinicians utilised it within a context of personal gain and loss. It is argued that the employment of these schemata affected the response of each group in terms of prioritisation of policy. This prioritisation was influenced by the nature of the 'audience' that needed to be satisfied that policy was implemented. The result was that policy was implemented with regard to what was 'sufficient' rather than absolute in terms of 'audience' needs.

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Acknowledgements

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Glossary Of Significant Terms Used In This Study

A Commissioner	A term applied to a purchaser of health care services within the context of the health market established under the NHS and Community Care Act 1990.
A User	An individual who uses and is treated by mental health services and CMHTs, traditionally referred to as a patient.
Clinician	A qualified health care professional within the CMHT sometimes referred to in the text as 'a practitioner'.
CMHN	This term, standing for community mental health nurse, is used in the study to describe nurses working in CMHTs. It is the more modern term. At the time of data collection, the general term used to describe these nurses was CPN (community psychiatry nurse). Therefore in quotations respondents usually employ the term 'CPN'.
CMHT	Community Mental Health Team – a multi-disciplinary grouping of mental health professionals overseeing and delivering mental health care to a caseload of users living in the community.
CPA	Care Programme Approach, a set of guidelines governing the delivery of mental health services to users, with an emphasis on the appointment of a keyworker to co-ordinate and over see the delivery of a multi-disciplinary care plan to the user.
Heuristic	Mental rules of thumb', that are used at a conscious and unconscious level in making decisions.
Manager	An individual who serves in a middle or senior executive capacity within the District Health Authority or NHS Trust and who is primarily engaged in overseeing the management of clinical services as opposed to directly delivering them to users in face-to-face contact.
NHS Trust	NHS Trust were established under the NHS and Community Care (1990) and usually centred around on an NHS hospital. They were provided with a greater degree of managerial independence from the district health authority and central government compared to other NHS services.
SMI	Severe mental illness, more recently referred to SEMI (severe and enduring mental illness). Usually identified with people suffering schizophrenia. The policy priority group of users to receive mental health services.
Street level Bureaucrat	A public service worker whose primary mode of work is to engage in direct face-to-face contact with members of the public. In this study it refers to the members of the CMHT

CHAPTER ONE

Introduction – Focus, Catalyst And Structure

1.0 Introduction

Interest in implementation research, active during the 1970s and 1980s, waned in the 1990s and has only recently revived (Lester and Goggin, 1998; O'Toole, 2000). It is argued this lack of interest during the 1990s reflected a less ambitious policy agenda in many countries (Bressers *et al.*, 2000). However, mental health policy in the United Kingdom at this time saw changes that were both radical, in that the policy trend towards care in the community accelerated, and regressive, in that there was an increasing emphasis on clinicians 'policing' the behaviour of users living in the community.

Discussion of mental health policy during this time appeared to often assume a 'normative' perspective in which implementation was examined within a 'technocratic' or instrumentalist framework that focused on the question 'How can we ensure that service mechanisms are successfully implemented to achieve policy aims?' Following such an approach in mental health policy analysis, it may be argued, can lead to a linear and administrative perspective that ignores a more person-centred analysis (Lewis and Maruna, 1998). Yet implementation is often iterative and may involve a continuum of rational and affective elements that influence operationalisation at the individual and agency level (Spillane *et al.*, 2002). Thus it is argued analysis should examine local group and individual processes (Bressers *et al.*, 2000). This is a particular consideration in the study of implementation within a health care setting since the interaction of personal contact; emotion; stress; values; hierarchy and low-level discretion are often prominent features of the work environment (Dunn and Ritter, 1995; Handy, 1995).

This study explores and describes the influence of the relationships, attitudes and feelings of individual actors, Community Mental Health Teams (CMHTs) and local

management on mental health policy implementation. It does not concentrate on the issue of mental health policy development and its implementation over the long-term, that is an examination of policy with reference to macro-theoretical and teleological concepts such as Marxist or Cyclical perspectives. It examines issues of implementation through an exploration of associations and iterative connections between 'actors' charged with operationalisation at the micro and meso level during a particular chronology – the first half of 1997 – in two CMHTs based in one mental health trust in London.

Use is made of the work of a number of theoretical writers on policy implementation to 'ground' this study. However, the work of two are particularly emphasised - Lipsky's (1980) work on 'street level bureaucracy'; and Fisher's (1998) work on decision heuristics within resource constraints. The perspectives of these writers are emphasised because of their incorporation of the relational elements of individuals' attitudes and affect with their negotiation of the contexts in which they operate.

Lincoln and Guba (1985) assert that the values of the inquirer in a research project reflect the problem chosen to study, the choice of the substantive theory or paradigm, that is used to guide the investigation, analysis and interpretation. The significance of these value paradigms are emphasised by Sjoberg *et al.*'s (1991) contention that the 'efforts of the researcher are shaped by the social and cultural context in which they operate' (p.68) and Johnson *et al.*'s (2001) argument that it is incumbent upon the researcher to demonstrate integrity of method through providing a clear, honest and self-critical account as it relates to personal views/ prejudices and pressures during the research process. The purpose of this introduction therefore is to highlight what led me to pursue this study (Section 1.1); provide a justification for the study (Section 1.2); highlight idiosyncrasies that might have a bearing on its conclusions (Section 1.3) and to give a brief overview of the structure and contents herein (Sections 1.4 and 1.5).

1.1 Catalyst for this study

A number of personal and professional beliefs and experiences provided the impetus to embark on this study. I believe in the founding principle of the NHS that clinical

calculations with regard the treatment and care of the individual patient should be purely related to their medical problems and not cost.

At a professional level, I had worked as a ward manager in acute psychiatry from 1989 to 1991, during which time the NHS experienced major changes in which an emphasis on resource management and accountability for resource use started to make itself felt on my ward. Budget management and assumption of 24-hour responsibility by ward managers emphasised a professional accountability that went beyond the traditional professional responsibility for the care of the individual to something wider (Wells, 1999).

During these two years in clinical management I pursued a part time taught Masters course in Care, Policy and Management, which raised my political and philosophical awareness about the issues involved consequent of the changes in NHS orientation at this time. In particular, I became interested in the conflicts that could be set up for mental health care practitioners between managing a resource limited budget and the traditional clinical credo of the relationship between clinician and individual patient (Wells, 1994; Wells, 1995).

This issue was further emphasised for me during 1993 when conducting a small-scale research project that focused on the educational environment of a psychiatric unit. I found, during the course of this research that the policy re-orientation to community care for the mentally ill had left ward based staff to interpret a new practice milieu in a guidance vacuum that often left them feeling undervalued, vulnerable and unable to self-fulfil in their work (Wells, 1995a).

Thus I had a number of experiences that led to an interest in the influence of political economy on professional/ personal views of clinicians and how these change (or not) to accommodate policy. I decided to pursue this interest in the form of doctoral studies. Initially, I intended to focus on the relationship of practice to resource management (Wells, 1996). However, the growing public concern and political controversy surrounding community care policy and the mentally ill in general led to a decision to

widen the study to include how practitioners and local managers make sense of policy in a climate of political controversy and resource limits (Wells, 1997; 1998). I chose to focus on community mental health because it seemed to me that the issues of which I was aware were most likely to be effectively illustrated in this area at the particular time.

Therefore, the catalyst for this study was a combination of reactive elements over time involving my work experiences; interaction and empathy with the problems of other professionals; a move to a new work environment that encouraged research and a growth in awareness that the issues in which I was interested were part of a wider 'political' context.

1.2 Justification for this study

During the 1990s there was a policy and professional emphasis on team working within UK community mental health services, exemplified by the widespread adoption of a community mental health team (CMHT) service orientation (Sharkey, 2000). However, the configuration of such teams varied greatly from region to region and NHS Trust to Trust[1], with no national policy as to which professionals should be encompassed within them nor operation (Onyett, 1999).

A number of studies of team working within CMHTs examined the inter-relationships between professionals within these teams (Onyett, 1997; Mistral and Velleman, 1997) inter-agency collaboration as mediated through these teams (Statham, 1994; Social Services Inspectorate, 1995), the relationship of CMHTs to management structures (Onyett *et al.*, 1997) the clinical focus of their effort (Brooker and White, 1997; Chalk, 1999) and the validity of the CMHT model (Galvin and McCarthy, 1994; Onyett and Ford, 1996). Towards the end of the decade attempts to provide some definitive answers to these issues were explored through national and local discussion groups comprised of stakeholders, academics, managers and practitioners (Norman and Peck,

[1] NHS Trust were established under the NHS and Community Care (1990) and usually centred around on an NHS hospital. They were provided with a greater degree of managerial independence from the district health authority and central government compared to other NHS services.

1999). However in terms of official policy the issues around CMHTs remained largely unresolved.

UK mental health policy developments in the 1990s, driven by political concerns (Towell *et al.*, 1997), had a rhetorical tenor that created an atmosphere of ambiguity and contradiction rather than an effective guide to action. Taken from this perspective, there are two striking features about much of the literature. The first is that studies which examine policy issues at 'street level' (for example Shepherd *et al.*, 1995; Whittle and Mitchell, 1997) tend to eschew examination of how practitioners interpret and accommodate policy with which they disagree, preferring to focus on the barriers between agencies and professionals. This focus on *co-ordination* issues it appears is a traditional point of blame and debate amongst policy formulators when implementation goals appear to be problematic (Pressman and Wildavsky, 1984).

The second factor flows from the first in that there appears to be an underpinning assumption that community mental health policy is a technical matter of operationalisation in which, for example, improved structures of team working are a means through which compliance with policy can be achieved (Onyett *et al.*, 1995; Øvretveit, 1995). What is notable, as Ramon (1996) has pointed out, is that such studies tend to ignore the 'political' aspects of policy implementation as experienced by practitioners. As Rogers and Pilgrim (1996) argue, the direct influence of practitioners is highly significant in mental health policy and, therefore, their views on policy legitimacy are important.

From this stance practitioners are shapers and mediators of policy on an implementation continuum. One therefore needs to understand individual practitioner perspectives on policy and how these are mediated and modified in relation to those held by colleagues and the local socio-political context (Dressler and Lipsky, 1989). Thus an analysis of mental health policy needs to understand the interactive nature of the macro and micro levels of policy (Rochfort, 1988). One is therefore examining a process of *mutual shaping* (Lincoln and Guba, 1985), interaction and whether or not potential cognitive

dissonances at the micro level are reconciled through the implementation process (Cherniss, 1995).

Yet, implementation at the "coal face" is often neglected within the promulgated policy strategies. For example, the Tomlinson Report devoted only three of its 67 pages to how its recommendations should be implemented (Tomlinson, 1992). Indeed, there appears to be a bias amongst central policy makers to regard those at local level as merely instruments of policy rather than contributors to policy (Towell *et al.*, 1997). Government interest in issues of implementation are now of more specific concern in UK mental health policy (Department of Health, 2001) and yet the relationship between central policy goals and local implementers remains a problematic one (House of Commons Select Committee on Public Administration, 2003). It therefore remains apposite to examine these issues within a local context.

1.3. The London context

This study focuses on a mental health Trust located in the London area during 1997. Mental health services in London, as affected by policy, differed in a number of ways from the rest of England to which the reader should be alerted since these may have affected some of the issues raised in the data[2]. London's health care system was viewed as ineffective in delivering health care, with established patterns of provision resistant to re-orientation (Harrison, 1997). London has an ethnically and culturally diverse population;[3] a high concentration of health problems; for example 35% of those treated for substance misuse live in London and a high concentration of mentally disordered offenders (MDOs) (Harrison, 1997).

By 1997 the general view of London psychiatric services was that they could not meet the demands placed upon them, particularly in the inner city (Powell *et al.*, 1995), based on the resources allocated through the central government funding formula (Goldberg, 1997). Bed occupancy was the highest in England (Hollander *et al.*, 1996), running at 125% (Goldberg, 1997), with more compulsorily detained patients per capita than any

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[2] It should also be noted that 1997 was a general election year in which participants expected a change of Government and therefore policy. In fact the Government did change half-way through data collection, in May 1997. This too may have influenced participants expressed views.

[3] It had 77% of all Black Africans and 55% of all Black Caribbeans living in the UK at the time of data collection.

other UK city (Goldberg, 1997). The Mental Illness Needs Index (MINI) used to allocate resources was shown to be inadequate to meet the level of psychiatric need in the Capital because it assumed that needs were normally distributed and that there was a uniformity of service delivery across the city, which was not actually a fact on the ground (Chisholm *et al.*, 1997).

Community mental health services were not uniform across London, though most areas had multi-disciplinary teams and sectorisation, with 17% of trusts sectorised according to GP areas (Kerwick *et al.,* 1997). However, over 60% of trusts did not have dedicated premises for CMHTs and most community services were only provided in office hours (Johnson *et al.*, 1997). Indeed, there was a general shortage of mental health personnel, with recruitment of psychiatric consultants in decline and just 42% of trusts able to provide Community Mental Health Nurses (CMHN) to more than 90% of patients (Johnson *et al.*, 1997). There was a five-fold variation across London for allocating users to high support facilities, and 10-fold variation for low support (Johnson *et al.*, 1997).

Health care management in London in general during the 1990s experienced a period of turbulence that was different from the rest of the country (Towell *et al.*, 1997). In addition to the implementation of the Conservative Government's internal market policy of the 'purchaser/ provider' split, separating the management of hospitals from health authorities, there was a general restructuring of health services as a consequence of the Tomlinson Report and the activities of the London Implementation Group (LIG), established to translate the Report's recommendations into reality on the (Tomlinson, 1992).

The general air of uncertainty generated by the internal market policy was further exacerbated by decisions about which London health services were to be amalgamated or replaced. One influential report stated that managers of London mental health services felt unable to manage the process of change, because of poor budgets and high job instability (Peck *et al.*, 1997). However, proportionately, London purchasers spent

35% more of their health budgets on mental health than elsewhere in the country, with an average spend in inner London of 18.6%, whilst in outer London it was 13.7%.

Added to these uncertainties and discontents was the fact that London hosted most major academic and campaigning organisations in health care as well as the political and media organisations of the nation. This meant that change in London was placed under more intense scrutiny than anywhere else. This helps to explain why despite the fact that policy rhetoric emphasised a "negotiating" model of central/ local relations, the reality was and to some degree remains that central Government was more sensitive to criticisms and issues involving London health care than elsewhere and therefore more likely to react to London events.

For example, the murder of Jonathan Zito by Christopher Clunis on the London underground meant that a local failure was generated into a national and political concern, which increased the pressure on local agencies in general and central Government in particular to allay public concern that community care policy posed a threat to public safety (Wells, 1998). An NHS Executive Briefing Paper on Mental Health Services outlined the "key questions for the public in London" (NHS Executive, 1996) that had to be addressed and thereby, provides an indication of the "political" concerns of central government at the time (See Box. 1.1).

- Are there enough acute psychiatric inpatient beds in London?
- Are bed pressures leading to people being discharged too soon?
- How can community services cope with the changes?
- Is the planned closure of large long-stay hospitals contributing to acute bed pressures and homelessness?
- Are we losing mental health services in London rather than seeing them develop?
- Are Londoners in growing danger of violence from people with mental illness?

Box 1.1

Government's Perception of Public Questions About London Mental Health Policy
(Source: NHS Executive (1996) Mental Health Services in London Briefing Paper No 1 Department of Health Leeds)

Overall, mental health services and their staff in London were subjected to an intensity of psychiatric need, lack of resources, reorganisation and public and political scrutiny

that was unlikely to be replicated in the rest of the country. This needs to be borne in mind when assessing the results of this study. Yet one also needs to recognise that the issues that affected London's mental health services initiated political responses that shaped mental health services across England. Therefore, the reactions and perceptions of staff in London have a significance for mental health services elsewhere in the country.

1.4 Underpinning theory and structure of this study

Qualitative case study is used as the overarching investigative and methodological construction informing this study design and presentation. The approach was chosen because it allows for levels of analysis between individuals and context. It is widely used to investigate similar issues (See Chapter 6). The underpinning theoretical work relating to the research issue is a combination of Lipsky's theory of street level bureaucracy (Lipsky, 1980) and Fisher's work on decision making within resource constraints (Fisher, 1998). However, other theoretical work on policy implementation (for example, Guba, 1984; Pressman, and Wildavsky, 1984) informed the overall theoretical perspectives that were developed (See Chapter 4).

The relevant literature on mental health policy as it relates to implementation is very large encompassing as it does literature on theory, policy formulation and implementation, the nature of mental illness, the mental health professions, service delivery, CMHTs, clinical and resource management, organisational psychology and the attitudes of society towards mental illness. In order to manage material effectively decisions were made as to literature focus and that which would briefly be surveyed. Therefore, whilst literature in all the aforementioned fields was considered, the primary focus was on mental health policy literature as it related to developments in the UK during the 1990s, literature on CMHTs at this time and theoretical literature on implementation. This literature seemed the most relevant for the purpose of the study design and analysis.[4]

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[4] For an explication of the literature search strategy used in this study I direct the reader to consult Appendix A.

The presentation of this case study follows the three guiding constituents of qualitative method as stated by Hamel *et al.*, (1993), 'describing, understanding and explaining' (p.39). These have the advantage of having a sequential relationship, which was felt important since events and their sequence play a role in determining responses. The use of narrative can be particularly strong in delineating a sequence of events. With reference to the primary issue in this case study it has been argued that individuals experience and make sense of their lives in narrative form (Orum *et al.*, 1991). However, narrative case study has been seen as less 'scientific' and therefore less valid as a means of presenting data (Orum *et al.*, 1991), reflecting perhaps the separation of the 'Arts' from the 'Sciences'. Orum *et al.*, (1991) argue that the narrative approach can be focused and disciplined, "vivid description is not the less scientific because it is descriptive" (Orum *et al.*, 1991:20). Indeed, the strength in conveying analysis through narrative can be seen in one of the classic studies on implementation, Pressman and Wildavsky's (1984)'*Implementation*'.

In this context Seale (1999) notes the decline in the overt presence of what is termed the *authorial voice* (Glasser and Strauss, 1967) in research accounts, which can be viewed as the importance of narrative in presenting a study. Seale (1999) argues the *authorial voice* is an attempt to facilitate the concept of narrative as an aid to the development of a persuasive analysis that also allows the reader to assess the fallibilistic context and nature of that analysis. This is particularly important with regard to any claims that may be made for generalisation as it facilitates the reader from 'receiving' contexts to assess the degree to which generalisations are or are not reflected in their own contexts and experience, thereby assessing the degree to which other interpretations can be drawn from the data (Hammersley, 1992).

Recent work on standards in qualitative research (Spencer *et al.*, 2003) emphasises the importance of communicating clarity in relation to use of method, analytical process, evidence and derived conclusions. Cartwright and Seale's (1990) '*The Natural History of a Survey*' provides an example of a combined narrative and 'scientific' account of the process of conducting a quantitative survey. It was decided therefore to utilise a combined approach as opposed to an exclusively narrative one, as exemplified in

studies by Protass (1978) and Wetherley (1979). Data that would benefit from a sequential presentation is written in a narrative format, for example Chapters Six, Seven, Eight and Nine. However, data analysis of interviews, and observation is presented through identified themes and categories.

Chapters Two and Three examines the development of mental health policy in the UK during the 1990s and the literature as it relates to CMHTs. They focus on the debate concerning CMHTs' compliance with policy, particularly CPA. Attempts by Government to influence CMHTs' compliance with central policy requirements are considered. The apparent importance of the relationship between the internalisation of policy rhetoric and policy compliance is highlighted in these chapters.

Chapters Four and Five consider relevant theoretical literature as it relates to the issues discussed in Chapters Two and Three. Following a survey and critique of the general theoretical literature on mental health policy, Chapter Four discusses the approach one needs to adopt for mental health policy analysis, arguing for multiple levels that start from the local implementation perspective. Consideration of the role economics has come to play in health as it particularly relates to clinical decision-making leads to a discussion of Fisher's decision-making heuristics in Chapter Five. This is then followed by a detailed discussion and critique of Michael Lipsky's theory of *street level bureaucracy.* Chapter Five concludes by outlining a conceptual framework used to guide the case study investigation, research aims and objectives.

Chapter Six discusses the reasons for the choice of case study as the methodological approach used within this study. Following this, the Chapter considers issues in defining the boundaries of 'the case' and the relationship of case study to generalisation.

Chapter Seven describes the process of study design, data collection and analysis. A total of 45 individuals were interviewed either individually or in groups and two CMHTs (designated CMHT A and CMHT B) were observed over a period of six months. This Chapter emphasises the importance of reflexivity in the research process and its influence on the relationship with the research environment.

Chapters Eight and Nine provide the reader with a comprehensive view of the case site environment in which respondents operated. The intention is to better inform understanding of 'the case' and to assist the reader in assessing the degree of transferability of findings.

Chapters Ten and Eleven present the analysis of managers' perspectives on policy and its implementation. It is argued that managers' sense making of policy was based on interpretations of its significance for their local context and this affected their decisions about its implementation. These judgements were predicated on an interaction of heuristic frames of reference with intra- and inter- affective factors and the degree to which implementation needed projection to national as opposed to local audiences.

Chapters Twelve and Thirteen discuss the data as it relates to the two CMHTs and group interviews that took place with medical staff and professionals allied to medicine (PAMS). It is argued that clinicians and teams utilised two schemata in their interpretation and implementation of policy involving an internalised 'economic' view of users and perceptions of personal risk in implementation.

Chapter Fourteen presents a synthesis of the above analysis, comparing the differences and similarities between managers and clinicians in relation to the research questions and locates the conclusions within the theoretical and empirical literature. It is argued that a significant heuristic guiding both a number of managers' and clinicians' approach to policy was implementation 'sufficiency' in relation to meeting the agenda of the particular policy and affected 'audience'. It then highlights some of the study's weaknesses, to which the reader needs to be alert when assessing the study's conclusion. Finally it suggests areas for future investigation.

PART I

POLICY AND THEORY

CHAPTER TWO

NHS Community Mental Health Services in the 1990s:

Issues of Policy and Implementation

2.0 Introduction

During the 1990s it became apparent that the Community Mental Health Team (CMHT) was a favoured option through which much community mental health policy would be delivered (Wells, 1997; Sharkey, 2000). This Chapter considers the literature on community mental health services as it relates to issues of mental health policy in the UK at this time.

Section 2.1 notes the increased interest on the part of Government in mental health policy during the 1990s, locating this within a wider international context, and linking this interest with a government determination to control expenditure. Section 2.2 discusses the tensions contained within what was called the 'internal market' of 'purchasers' and 'providers' consequent of the enactment of the NHS and Community Care Act (Department of Health, 1990; Towell *et al.*, 1997) with the philosophy and structures underpinning mental health services. Section 2.3 considers the impact of GP fund holders on the ability of local services to implement central policy directives. The establishment of community care service delivery guidelines and processes (known as the Care Programme Approach) in response to previous criticisms of care delivery (Audit Commission, 1986; Spokes *et al.*, 1988; House of Commons Select Committee on Health, 1994) and the issues this raised is explored in Section 2.4. Section 2.5 discusses the political response to a public perception that community mental health policy was in crisis (Muijen, 1996; Payne, 1999) in the form of the Mental Health (Care in the Community) Act (1995) and Supervised Discharge. Finally, Section 2.6 concludes by arguing that community mental health policy in the 1990s

was driven by the combination of the need to ensure fiscal costs were constrained with a need to demonstrate a responsiveness to public concerns over community care through a 'policy rhetoric' of action.

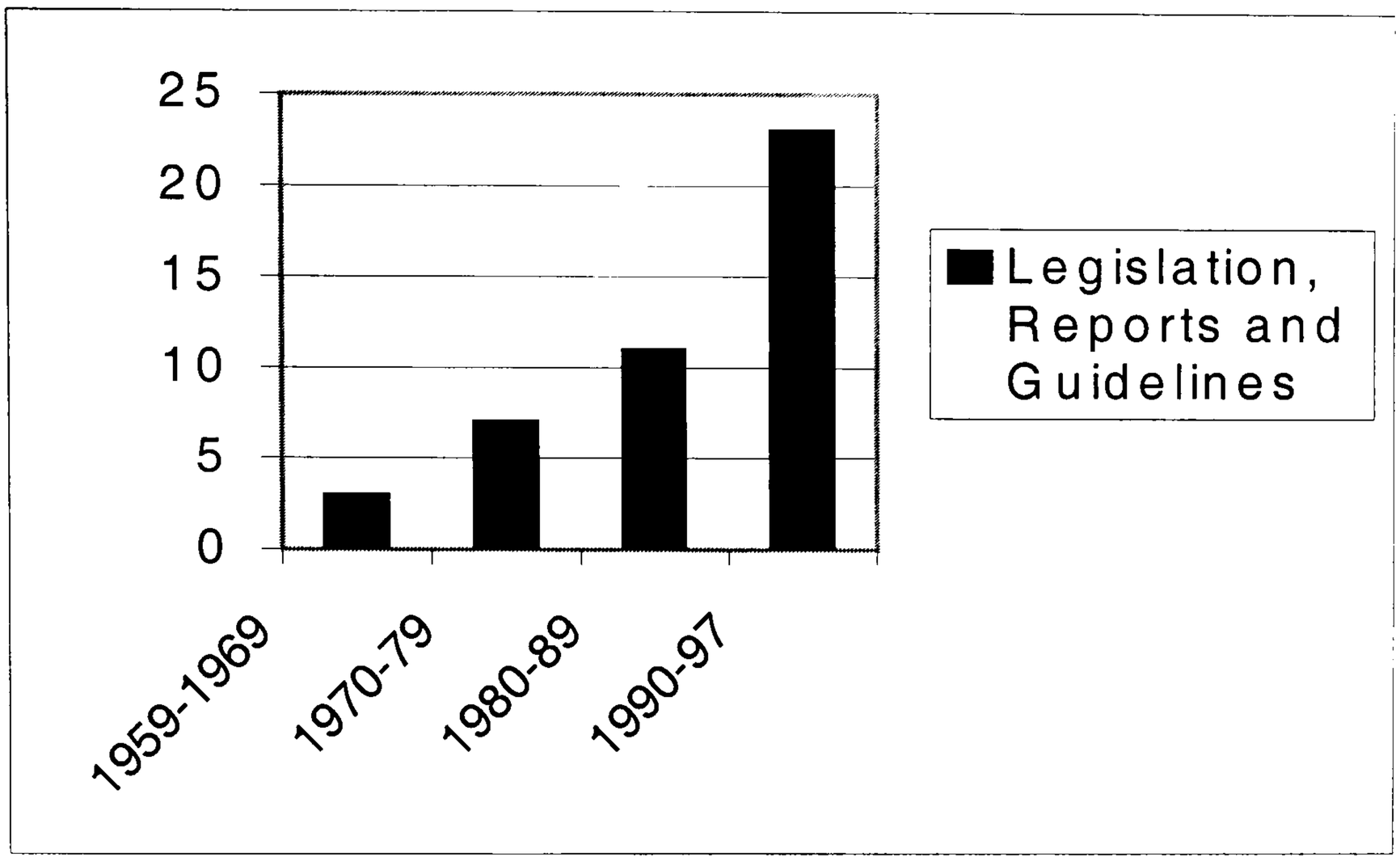

Figure 2.1
Incremental increase in
major legislation, official reports, guidelines and initiatives
1959 to 1997
(Sources: Roy *et al.*, 1996; Lelliott *et al.*, 1997)

2.1 Mental health policy - rhetoric and fiscal restraint

A brief count comparing the number of policy documents, initiatives and official government reports from the 1950s to 1997 indicates an increased political interest/ sensitivity with regard the nature of mental health care in the 1990s (See fig. 2.1 and Appendix B). This was part of a trend to be found in many English speaking countries at this time; in which the disjuncture between mental health policies, fragmented services, a government focus on users of services with enduring mental health problems and the means of meeting their multiple social and individual needs were all subjects of debate (Menzel, 1995; Vandiver 1997; Mechanic, 1999).

The significant policy factor in the UK was the determination of central Government to maintain tight fiscal control on the resource committing behaviour of mental health

clinicians (Hogman, 1996; Knapp, 1996). This was 'masked' by a policy rhetoric that claimed the provision of mental health care was a national and local priority (NHS Executive, 1996a). Yet Redmayne *et al.* (1993) found that although commissioners consistently identified mental health services as a top priority, they actually ranked third in spending on community services. A comparison of expenditure per head of population in London for the fiscal year 1994-1995 found that local authorities spent eight times more on services for the elderly than on mental health services (Woodley *et al.*, 1995). To understand this disjuncture one needs to consider the mental health service structures established under the NHS and Community Care Act (1990) within the context of what was called the 'internal market'.

- A *case identification, needs assessment*, and *care planning system* which is integrated with the *Care Programme Approach*
- A range of *hospital and community beds*, and *bed management strategies* to use those places appropriately
- *Case management, rehabilitation* and *assertive outreach* provision
- A network of *day care, education* and *employment* options
- *Crisis intervention* and *prevention* services
- Options for *assessment* and *consultation services* in *hospital, home* and *primary care clinics*
- A *primary care liaison system* negotiated with local primary health care teams
- *Initiatives with community agencies and carers*, including service protocols, joint planning and provision of 24 hour, 7 day services
- A range of *effective clinical and management interventions*, offered by the appropriately trained staff
- *User involvement* in service planning and evaluation and *user advocacy projects*.

Box 2.1
Structuring community mental health services in the UK

2.2 Community mental health care and the 'internal market'

Stein and Test (1990) from the USA set out an 'ideal model' for a community based mental health service. They advocated a structure based on a core team that would co-ordinate and provide a range of medical, psychiatric and social services to a user/ patient. Their model was influential in structuring the way academics, mental health professionals and central government conceived of community mental health services. The *Health of the Nation Key Area Handbook* (Department of Health, 1994) and *The Spectrum of Care* (Department of

Health, 1996) contained a number of recommendations for the structuring of local community mental health services that seemed to draw from the Stein and Test's (1990) model (See Box 2.1).

It can be seen that the 'ideal' type of community care service was highly complex, demanding the co-operation and integration of a range of services, agencies and professionals that traditionally saw themselves as separate collaborators; for example hospitals and local authority social welfare departments, rather than integrated partners (Peck and Parker, 1998). A London based study of senior mental health service managers found that over a third of the managers surveyed identified joint working as a source of concern in their work (Peck *et al.*, 1997).

At the same time that government policy appeared to require these agencies to collaborate more intimately (Department of Health, 1990a and b; Department of Health, 1991; Department of Health and Department of the Environment, 1995; Social Services Inspectorate, 1995) central Government implemented a policy of an 'internal' or 'managed' market in health care (Carruthers *et al.*, 1995). 'Providers' of health services, such as hospital trusts, would compete with one another to secure contracts to provide services for 'purchasers' or commissioners (health authorities and General Practitioner (GP) fund holders, that is selected GPs who were given their own 'purchasing budget') of health care services as part of a government attempt to drive down the costs of health care (Hunter, 1993).

The incentive to drive down costs was provided by a requirement that commissioners purchase services within an allocated budget. However, the funding formula used to allocate resources to commissioners was based on a capitation weighted by a standardised mortality ratio (under 75), which was widely seen as failing to recognise the extra resources needed to 'purchase' and maintain effective mental health services, particularly in inner urban areas of economic and social deprivation (House of Commons Health Select Committee, 1994). Commissioners of mental health services were consequently confronted

with managing acute resource pressures in relation to need. As a result a range of conflicting incentives operated in which health authorities, GP fund holders and social services attempted to 'cost-shift' responsibilities for meeting users' needs between each other, which often blocked effective integration and delivery of services (Muijen and Hadley, 1995).

A number of commentators pointed out not only the inherent policy contradictions resulting from the commissioning freedoms associated with the 'internal market' (Flynn *et al.*, 1995) but called into question whether those charged with operating the market system, the commissioners, had either the training, experience or independent information of providers to make informed purchasing decisions (Forder *et al.*, 1996; Audit Commission, 1994). One study (Salter, 1994), for example, found that most commissioning decisions were based not upon rational consideration of performance and evidence but on personal relations and prejudices operating between commissioners and providers. Thus added to the general difficulty of getting agencies and professionals to work together in an integrated way was the competitive milieu in which they found themselves operating where formal systems were not necessarily the most significant in determining market operations and planning.

2.3 GP fund holders and community mental health policy

A particular contradiction that encompassed many of these issues was the nature of the GP fund holder's role as a purchaser of care for the individual and the 'population purchasing' role of the health authorities (Wall, 1993; Ham, 1996). Within mental health services this focused on the health authorities' obligation to follow central Government exhortations for community mental health services to focus on people with enduring and severe mental illness (SMI) and the desire of GP fund holders to 'purchase' community services that would meet the needs of their individual patients often dubbed the 'worried well' (Monkley-Poole, 1995; Hannigan *et al.*, 1997).

The GP fund holder scheme (NHS Management Executive, 1992) was fully operationalised in 1994 (NHS Executive, 1994 a and b). GPs who so wished were to be given control of budgets independent of health authorities in order to purchase a range of out-patient and community services (See Box 2.2) for their patients from wherever they saw fit (NHS Executive, 1995a, b and c).

Includes

Counselling;
Referrals to all members of the mental health care team including consultant psychiatrists, CMHNs, OTs, psychotherapists, psychologists but excluding psychiatric social worker;
NHS service for people with learning disabilities;
Referrals for services for people with learning disabilities from other agencies
Day attendances for people with mental illness or learning disability;
Referrals made by CMHNs and community learning disability nurses for other services included within the GP fund holding scheme.

Excludes

Referral to mental health care team from other agencies;
Local Authority services for people with learning disabilities;
Mental health or learning disability in-patient care.

Box 2.2
List of mental health services that could be purchased by a GP fund holder

This freedom stood in marked contrast to the purchasing constraints faced by district health authorities, which became acute, particularly in the London area, in the financial year 1996/1997 owing to Government demands to further reduce spending (Butler, 1996, a and b). These, in an attempt to contain costs, placed a range of restrictions on non-fund holding GPs' and NHS Trusts' psychiatrists' powers to refer to other services (Muijen and Hadley, 1995), particularly in the area of referral to specialist and out of district services, (such referrals were known as Extra Contractual Referrals (ECR), which proved to be a regular source of resource spending concern (Saroj and Shires, 1994, House of Commons Select Committee on Health, 1996). Such restrictions were greatly resented and seen as illegitimate interference with clinical autonomy (Royal College of Physicians, 1995).

As the GP fund holder scheme became established so a number of variations upon it were tried around the country, the most radical of which were the total purchasing fund holders, whereby a practice was given a budget to buy all care (both hospital and community) for their patients (National Association of Health Authorities and Trusts, 1994; NHS Executive, 1995a). By 1995 40% of the population of England and Wales were covered by fund holding practices (Ham, 1995) encompassing 25% of all GP practices (Monkley-Poole, 1995) rising to 41% of the population and approximately 33% of all GP practices in 1996 (Cohen, 1996). By this time GP fund holders controlled 15% of NHS resources (Dean, 2001). A national survey of the level of per capita spending by GP fund holders on mental health services (Cohen, 1996) found a 15-fold range from £1.04 to £15.22.

Thus the scheme became associated in the minds of many within health care and beyond with the drive to reduce health costs through the introduction of more 'commercial' values into the NHS (Bradlow and Coulter, 1993); the establishment of the principle of inequity within the NHS (Exworthy *et al.* 1996) and finally the Government's determination to 'break' the dominance of the hospital consultant and to force secondary services to be more responsive to GPs' and individual patient needs (Cohen, 1996). The scheme also came to symbolise a perceived growth in an 'internal market' bureaucracy within the NHS that many secondary and tertiary service practitioners felt was burdensome and wasteful (Hudson, 1994).

Overall, the GP fund holder was seen by clinicians, the Government and commentators as a privileged agent of policy change who would shift the power to determine clinical provision and control of resources away from the secondary sector of hospital consultants to a 'primary care led NHS' (Cresswell, 1993; NHS Executive, 1994b). This 'primary care led policy' focused as it was on enhancing the power of local GP fund holders to influence secondary service provision introduced a conflict with national policy in other areas of community mental health care that was never fully resolved (Woolley, 1995; Royal College of General Practitioners, 1997). In particular, as the 1990s wore on national policy emphasised that local trusts should focus their attention on individuals with severe and

enduring mental illness (Audit Commission, 1994), though what this actually constituted was not definitively stated. However, in contrast GP fund holders often wished to purchase community mental health services for a range of patients and voiced concerns that the emerging emphasis on SMI was having a negative impact on the service they and their patients required from CMHTs (Hannigan *et al.*, 1997).

At a time when mental health NHS Trusts were under central Government pressure to reduce costs and health authority purchasing budgets were constrained, the 'purchasing' power of the GP fund holder could be an important source of income to trusts (Corney, 1996). Thus the potential of the GP fund holder to divert community mental health services' attention away from central policy concerns was enhanced (Audit Commission, 1994; Muijen and Hadley, 1995).

Brooker and White's (1997) survey of the caseloads of Community Mental Health Nurses (CMHNs) noted that they continued to focus on what were termed 'the worried well' rather than on those with enduring and severe mental illness. This may indicate the degree to which the purchasing power of GP fund holders could determine clinical caseloads in the face of central policy exhortation (Muijen and Hadley, 1995). For example, a number of GP fund holders used their purchasing power to re-orientate local out-patient services to meet their needs to work within their practices rather than in a multi-disciplinary team base, thereby raising questions about the fragmentation of local community mental health services (Corney, 1996). More interestingly, it may be argued, that Brooker and White's (1997) survey results indicate that at least one group of professionals, CMHNs, working within community mental health services shared the view of GP fund holders as to where their practice focus should be at this time.

Concern was voiced by a number of local health authorities and Government agencies about the policy difficulties raised by the purchasing independence of GP fund holding (Audit Commission, 1994; Anglia and Oxford Regional Health Authority and the NHS Executive, 1995). Attempts were made to deal with this difficulty through a number of

local and national policy initiatives to bring GP fund holders more directly into the policy making structure (Patmore, 1994) and an emphasis on the need for collaboration between health authorities and GP fund holders to develop joint local strategic health strategies (Audit Commission, 1994; Royal College of General Practitioners, 1997). However, despite these developments the essential dislike and policy tensions associated with GP fund holding remained unresolved. [5]

2.4 The tensions within the Care Programme Approach

The Care Programme Approach (CPA), introduced in April 1991, was identified by central Government as the preferred means of organizing psychiatric care and support for those patients discharged from psychiatric hospital into the community (Department of Health, 1990a, b and c). It laid down broad guidelines on assessment, identification of a key worker and consultation with the patient in planning their care. The aim of CPA was to ensure that patients discharged to live in the community would receive continuity of support within a planned package of health and social care within available resources. The specific form and content that CPA arrangements should take was left to local decision makers, that is commissioning and trust management, consultant psychiatrists and their colleagues (Hudson, 1993, Schneider, 1993).

The lack of prescriptive central guidelines as to form and content of the CPA was justified by Government to facilitate approaches to suit local conditions (Department of Health 1995a). A feature of this stance was that although the CPA extended the duty of health and social services to provide systematic aftercare, until the enactment of the Mental Health (Patients in the Community) Act, 1995, it had no statutory basis.

In addition to specific form and content, local decision makers were also left with the responsibility to balance care needs and individual wishes against the availability of local resources. However, the initial policy rhetoric surrounding the universal application of CPA made this balancing activity more difficult as research seemed to indicate that intensive

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[5] The scheme was abolished after the new Labour Government took power in 1997 (Department of Health, 1997; 1998).

community support could lead to higher in-patient admissions and further pressure on resources (Tyrer *et al.*, 1995). Thus CPA was likely to increase the demands on all services (Hogman, 1996) and indeed a recent longitudinal study seems to confirm this view (Cornwall *et al.*, 2001).

Onyett (1998) pointed out that the demands to provide an integrated package of care as envisioned by CPA meant that there needed to be a clear link with local social services who had, under Government policy, responsibility for the delivery of social support through what was known as case management (Department of Health, 1990a). However, the actual responsibility for the planning and co-ordination of such care under the CPA was wholly invested in key workers who were hospital based. As indicated above (Section 2.2), such diffusion of responsibility between differing professions and agencies was a cause for concern in terms of effective collaboration that Government policy avoided directly tackling (Higgins, 1995; Lewis, 1993).

As CPA implementation progressed it became clear that it would not be feasible from a resource point of view to provide all discharged patients with a comprehensive CPA plan (Hunter, 1994). NHS guidance therefore recommended (though did not insist upon) a tiered CPA, consisting of three levels, to be adopted so as to concentrate resources on people with the most severe mental health problems. These would be placed on level 1 and require the full multi-disciplinary care, usually in the form of CMHT management (Department of Health, 1995a). This was further emphasized by the 1995 Mental Health (Patients in the Community) Act, which required that resource priority be given to those individuals placed on supervised aftercare (discharge) orders (Department of Health 1995a).

At the same time however, the NHS Executive emphasized that others must receive CPA's basic elements, for example a care plan (NHS Training Executive, 1995) and that patients should not be discharged until adequate assessment of need had been carried out and appropriate resources supplied (Roy *et al.*, 1996). Yet, the closure of many in-patient beds had a detrimental effect on discharge planning and was claimed to be a significant factor in

'bed blocking' (Roy *et al.*, 1996). This, according to some, in turn led to greater pressure on CMHTs and managers to contain psychiatric disturbance in the community in order to reduce admissions to hospital and thereby ease the situation (Roy *et al.*, 1996).

Five Indicators of Severe Mental Illness (Department of Health, 1995)

- Suffer substantial disability as a result of their illness, such as an inability to care for themselves independently, to sustain relationships or to work;
- Are currently displaying florid symptoms; or
- Are suffering from a chronic, enduring condition;
- Have suffered recurring crises leading to frequent admissions/interventions;
- Occasion significant risk to their own safety or that of others.

Ten Item Rating Scale for Assessment of Severe Mental Illness (Wing *et al.*, 1995)

- Problems resulting from overactive, aggressive, disruptive or agitated behaviour by patient;
- Suicidal thoughts or behaviour; non-accidental self-injury;
- Problem-drinking or drug-taking
- Cognitive problems involving memory, orientation, understanding;
- Problems associated with physical illness or disability;
- Problems associated with hallucinations and delusions;
- Depressed mood;
- Other mental and behavioural problems;
- Problems with making supportive social relationships;
- Problems with Activities of Daily Living: overall disability;

Box 2.3
Contrasting assessment of what constituted SMI

Thus a policy rhetoric was established which maintained the appearance of a broad application of CPA, whilst legislation, operating guidance and resource constraints emphasized that it needed to be rationed through a tiered application and focused on particular groups, particularly those identified as having SMI, though process and focus was to be determined at local level. The local policy variance that this created was not helped by a refusal to provide a definition of severe and enduring mental illness. Instead the Department of Health cited five examples of SMI in one guidance document (Department of Health, 1995a), yet in another (Wing *et al.*, 1995) cited ten scaled behavioural and cognitive traits (See Box 2.3).

In effect therefore central government suggested that assessment of need should be used to define priority yet eschewed any formal definition of what actually constituted 'need' through the provision of specific guidance on who constituted the most 'needy'. The result, as a study by Patmore and Weaver (1995) found was a wide variation amongst different CMHTs, often within the same clinical service as to who precisely constituted the seriously mental ill.

The lack of prescriptive requirements in order to provide a uniform configuration of CPA might help to explain its slow adoption across the NHS. One study found that mental health practitioners were equivocal and ignorant of CPA (Social Services Inspectorate, 1995). An editorial in The Health Service Journal noted, "the desultory way in which the care programme approach has been implemented" (Health Service Journal, 1995). For example, in Camden and Islington the local Community Health Services NHS Trust had taken three and a half years to fully implement CPA (Crawford *et al.*, 1997). It was only by early 1998 that all 180 mental health trusts in England had CPA arrangements formally in place (Bindman *et al.*, 1998).

It can be argued that the Government required local managers and clinicians to strike a balance between managing demand, needs and resources so the latter were not exceeded, but it avoided direct responsibility for what could and could not be met. The lack of a uniform and unambiguous definition of SMI in relation to demand was particularly important due to the potential pressure placed on resources by the enactment of the Mental Health (Patients in The Community) Act (1995) and Supervised Discharge (MIND, 1995).

2.5 Supervised Discharge

It has been argued that the picture in the public mind of mental health services in the 1990s was dominated by homicide (Stanley and Manthorpe, 2001) particularly so in the first half of the 1990s (Wells, 1997). These public concerns initiated a political response, in terms of the then Secretary of State, Virginia Bottomley's publication of a Ten-point policy plan

(Department of Health, 1993;) in which the containment of risk within the community was the central theme (Hallam, 2002).

The plan included a review of care for people with schizophrenia and changes to the extended leave option available to clinicians from six months to one year. However, the most prominent element of the plan was a proposal to establish local supervision registers to identify those mentally ill people in the community deemed 'vulnerable' or 'at risk' (Department of Health, 1994a), 'at risk' being defined as having a potential to harm others, self or in danger of serious self-neglect. The purpose of this was to assist health and social services to provide resources for such people and make available to interested parties relevant information (Bean, 2001). Yet as Bean (2001) points out this definition of vulnerable and 'at risk' was open to wide interpretation, thereby ensuring both a lack of uniformity in application and resourcing between authorities and practitioners.

The plan also promised new legislation in 1995 to ensure such 'at risk' individuals received and complied with their care programme through a form of compulsory supervision ("aftercare under supervision"). This became known as 'Supervised Discharge' (Wells, 1997).

The 1995 Mental Health (Patients in the Community) Act provided the authority for the use of compulsion to take and convey an individual placed on a Supervised Discharge order to a place of residence, to attend an agreed location and to provide access to their place of residence by a key worker. It did not allow a fast track route for readmission or compulsory medication. Treatment compliance of mentally ill people in the community had been a prominent issue within the UK clinical literature since at least 1985 (Bluglass 1993). This mainly focused on compliance with medication. Thus the Act failed to address the issue of most concern to a number of clinicians.

The accompanying guidance for the use of Supervised Discharge orders (NHS Executive, 1996a) emphasised it was up to local trusts, purchasers and clinicians to establish protocols

for its use. Managers were to "ensure that the guidance is brought to the immediate attention of those responsible for its implementation" (NHS, 1996b). Implementation was to be achieved with no new resources. More importantly, the use of Supervised Discharge was to be at the discretion of clinicians. Therefore, as in the case of CPA, central Government appeared to establish an environment of doubt where uniformity of practice and implementation was unlikely to occur.

The degree to which Government was prepared to enforce the use of these measures at local level may be gauged by the fact that in 1995 the Mental Health Act Commission (1995) noted a level of 'tokenism' at local level with regard to the implementation of Supervised Discharge. Thus by 1997 there were according to the Mental Health Act Commission (1999) only 318 people in England on Supervised Discharge compared to an estimate by the Department of Health of 3,000 suitable individuals for such an order (See also Bean, 2001). Consequently, this legislation may be seen as having a rhetorical purpose, to provide the public with reassurance that something had been done to address their concerns (Parkin, 1996), rather than an effective management of problems of care delivery, which would have had resource implications that Government were reluctant to concede.

This was the view taken by a number of patient and professional organizations (MIND, 1995; Atkinson, 1996). Fears were voiced that the legislation could be utilized to make an individual comply with inappropriate and under-resourced treatment plans and thereby exacerbate rather than ameliorate problems for both user and professional carer alike (Eastman, 1994). Clinicians in particular viewed the legislation with at best scepticism and at worst cynicism (Tomlin, 1995). For example, concerns that community professionals had inadequate resources to implement the new measures reinforced the view that the legislation delineated the responsibilities of the key worker without the means to fulfill them (Eastman, 1994). The legislation thus created a potentially perverse incentive for both patients and/or clinicians to demonstrate non-compliance with treatment in order to gain extra resources (Wells, 1998).

The 1995 legislation emphasised the *de facto* rationing role that mental health practitioners had to assume in relation to balancing demand against limited resources (Nolan and Caldock, 1996) and that policy guidance envisaged a greater role in this respect (Department of Health, 1996a). The Royal College of Psychiatrists (RCP), for example, voicing concern about supervision registers stated that the measurement of risk and associated inclusion criteria was imprecise, too wide and that sharing information from the register amongst agencies was a threat to patient confidentiality. The President of the RCP told the health secretary "If your policy on supervision registers is to be implemented with the commitment of our members, these points must be addressed" (Health Service Journal, 1994).

2.6 Conclusion

As the 1990s progressed community mental health policy seemed focused on allaying public fears about mentally ill people living in the community yet maintaining fidelity to the general policy of containing public expenditure. Whilst general parameters were established, Government eschewed explicit specification, which was belied by a policy rhetoric designed more for public consumption than policy clarification. Consequently, a number of policy ambiguities and contradictions were established, for example the diffusion of responsibility between local authority services, community mental services and individual keyworkers or the degree to which GP fund holders' market power could divert community mental health services away from focusing on SMI. The general funding formula used to fund mental health services and the Government refusal to give extra resources for supervision registers and supervised discharge established a de facto rationing system implemented within community mental health services through a tiered approach to CPA (something the original scheme never envisaged).

Overall responsibility for making sense of policy was delegated to local managers and clinicians. This effectively distanced central government from the consequences of these policy ambiguities and contradictions. It guaranteed a lack of uniformity of policy application between community mental health services. This last issue is intimately linked

with the mechanism through which community mental health policy priorities were to be delivered – the community mental health team (CMHT). This is examined in the following Chapter.

CHAPTER THREE

NHS Community Mental Health Services in the 1990s:

The Community Mental Health Team

3.0 Introduction

This Chapter explores the nature of the community mental health team during the 1990s and in particular the literature relating to their relationship to policy implementation. Section 3.1 examines the structure of community mental health services as reflected in the composition and function of CMHTs and the relationship between their definitions of practice focus and resources.

Section 3.2 examines issues of policy compliance as they affected the CMHT and whether policy implementation in this context should be seen as a continuum rather than an absolute, in which compliance could vary between teams and even within teams. In section 3.3 the relationship of practitioner stress and burnout to policy implementation is considered and the degree to which the ability to exercise autonomy and discretion in day-to-day practice was significant in this relationship.

Section 3.4 considers the various ways that Government attempted to control discretion whilst retaining practitioner flexibility, highlighting that all of the formal mechanisms of control had an inherent weakness – reliance on practitioner self-report. This theme is developed further in section 3.5, which examines government and managerial attempts to change practitioners' frame of reference when exercising discretion to one based upon the conception of 'risk' and its management. Finally, section 3.6 concludes with a consideration of the questions that this chapter raises. In particular the conclusion highlights the importance of the relationship between the internalisation of policy rhetoric

and policy compliance.

3.1 The composition of the CMHT and its focus of care

During the 1990s there was no agreed definition as to what constituted CMHT membership (Onyett, 1997). For example, Patmore and Weaver's (1995) study of multi-disciplinary teams providing mental health care in the community was entitled *Community Mental Health Teams: Lessons for Planners and Managers* yet confusingly in the text referred to these CMHTs as Community Mental Health Centres, under which they identified three different types of team structure and focus. Central Government did not prescribe a single format to define the primary duties and process of working for the CMHT. This led to variations between NHS mental health trusts as to the composition, reporting structures and clinical focus of teams, and an increased research interest in the issue (Onyett *et al.*, 1994; Øvretveit, 1997).

- Composed of at least three separate disciplines (including medical and psychiatric nursing, plus variable numbers of clinical psychologists, social workers and occupational therapists)
- Members are identified as individuals and are constant attendees as opposed to occasional attendance as a representative of a department
- Members acknowledge their membership and know the identity of the others.
- Regular team meetings are held to discuss a) team policies; b) management programmes of individual patients
- Team has policies that make it possible to identify a) a team leader when required; b) a key worker for each patient.
- It is agreed that most of the contacts with the patient will be by the key worker, who will be expected to make a variety of day-to-day decisions without necessarily referring to other or more professionally senior members of the team.
- Major decisions will always be discussed with the team.

Box 3.1
Characteristics of a CMHT (Cooper, 1990)

Cooper (1990) provides an early attempt to define the features of a community mental health team within a UK context (Box 3.1). He saw as central to their membership CMHNs[6], social workers and psychiatrists. He characterised the relationship between these

[6] At the time referred to as Community Psychiatric Nurses (CPNs).

disciplines as a collaborative one in which they worked regularly together, transmitting much of their individual professional expertise to the patient through a key worker. However, Cooper's (1990) construction of the CMHT appears to reflect not what actually arose but rather the older form of multi-disciplinary team (Opie, 1997).

- **'Targeted Care'** CMHT should only focus on people with severe and persistent mental health problems. CMHT should prioritise and act as 'gatekeeper' to the service.
- **'Access to a wide range of skills, services and opportunities of use to people with serious and long term mental health problems** teams should include social workers, psychiatrists, occupational therapists and community mental health nurses.
- **'Coordinated care'** intra-team and inter-agency co-ordination of inputs for the user by one individual within each team.
- **'Continuous high quality personal relationships between workers and service users'** core tasks with user carried out by one individual monitored and supported by the rest of the team.
- **'Opportunities for participation'** Power differences within the team need to be recognised, however members should be consulted prior to decisions being made.
- **'Community integration'** Use of non-specialist facilities to develop valued roles and "increase cost effectiveness"(p51)'
- **'Proactive 24-hour support and treatment'** A team approach to provide continuous and flexible care
- **'Clear aims and enhanced strategic operational management'** Operational team manager supervises compliance of CMHT members with operational policy, whilst clinical supervision remains within disciplines.
- **'Sustainability'** Team needs to have access to "*adequate*"(p.53, my italics) resources to work effectively over time, achieve role and responsibility clarity and work in a supportive environment.

Box 3.2
Nine Characteristics of an effective CMHT
(Onyett and Ford, 1996)

3.1(a) The CMHT's span of practice

Moss (1994) identified the ideal functions of the CMHT as consisting of on-going care for those with chronic serious psychiatric illness; 24 hour intervention and support and mutually agreed priorities of response by the team to requests for help from primary care. In this vein Onyett and Ford (1996) identified nine features of what they termed an

"effective" CMHT (Box 3.2). These features of 'effectiveness' were identified in the literature as imposing the greatest degree of difficulty in operationalising CMHT practice, for example targeted care and team leadership (Brooker and White, 1997; Øvretveit *et al.*, 1997). Of particular interest is the contrast in emphasis within Onyett and Ford's (1996) features of an effective CMHT compared to those of Cooper (1990). The initial contrast is that within Cooper's (1990) schema the emphasis was on the 'individuality' of the practitioner within the team and the implication that leadership of the team can change to fit changing circumstances.

Onyett and Ford (1996) however appeared to emphasise the subsumption of practitioner identity within the team, placing team leadership in the hands of one identified individual. More strikingly, it is clear that Cooper's (1990) conceptualisation of the service span of the CMHT was broad and more reflective of the traditional NHS 'professional' ethos of comprehensive treatment for all. Onyett and Ford's (1996) conceptualisation of service span was more narrow and appears driven by considerations of limited resources and the need to comply with policy imperatives.

One explanation for this difference between the two conceptions is the explicit 'New Public Management' ethos imported into the NHS during the 1990s (Harrison *et al.*, 1990; Hewison, 1999). More particularly it may be indicative of the degree to which at least those in the mental health research community internalised resource consciousness in their interpretive thinking as the 1990s progressed. Something that Government had attempted to instil in the public sector, and within the NHS initially in changes to the management structures within nursing during the 1980s (Harrsion and Pollitt, 1994; Wells, 1999).[7]

Onyett and Ford's (1996) focus on 'severe and persistent mental illness' (SMI), not only reflected the limits of resources on practice, but also the increased political concern that such people should be managed more effectively in the community so as to allay public anxiety about the potential for violence following discharge (House of Commons Health

[7] See Chapter 2, section 2.4 for further elaboration.

Select Committee on Health, 1994). Thus an impetus was created for policy to constrain overtly clinical focus and management of patient care. As part of this there developed a strong antithesis to CMHTs working with people with shorter term[8] mental health problems, known as the 'worried well', since this was seen as a waste of valuable team resources and 'muddying' the focus of their clinical effort (Bowers, 1997; Gournay, 1995), though there was an influential minority opinion that dissented from this view (Andrews and Teeson, 1994; Barker and Jackson, 1996)

This emphasis on chronicity, severity and potential for harm (either self or others) meant that as the 1990s wore on the role emphasis of the CMHT in policy and the literature changed from one of providing care and support for an individual to a more complex one of monitoring and intervening in the lives of individuals as an agent of social control in the community (Payne, 1999). This continues to be a theme in Government policy (Appleby, 1999). Such an emphasis had a potential to generate a tension between traditional practice values and philosophy of empowerment and support emphasised by a number of the disciplines to be found within the CMHT (Barker, 1996) with the exigencies of policy imperatives.

3.1(b) Membership of the CMHT

Onyett (1998) conducted a national survey of the composition of 302 CMHTs in 1993 and found that the most common professional group within such teams were CMHNs at 93%. This was followed by Social Workers at 86%. Consultant Psychiatrists were present in 79% of teams, whilst Clinical Psychologists were present in 71% and Occupational Therapists in 68%. Other disciplines found within the teams were generic mental health workers (37%); other specialist therapists (31%); doctors other than consultants (67%); nurses other than CMHNs (33%); administrative staff (85%) and volunteer staff (13%). Onyett (1998) summed the number of staff in each discipline across teams as a total percentage of the number of CMHT staff and found that CMHNs made up the largest part of the workforce at

[8] Also termed 'transient mental health problems' and associated with the neurotic end of mental health difficulties.

25%, followed by social workers at 12.2 %. Consultant Psychiatrists were ranked eighth at 6.6%. (Though these latter exercised a formal power within the system compared to other professionals in excess of what this figure suggests).

These figures illustrate a number of factors relevant to the relationship of CMHT membership to questions of policy implementation in the 1990s. Firstly, the CMHT at this time encompassed a wide variety of professional groups with considerable variance in their status and power as these relate to the organisation and implementation of mental health care policy. These variances were further emphasised by differences in statutory responsibilities (Dimond, 1997). Secondly, differences of care/ treatment philosophy existed between members of such teams based on accountability to different agencies, professional education and socialisation (Hilton *et al.*, 1995).

This issue was mainly explored in relation to social workers and psychiatry (Woof and Goldberg, 1988). More recently such differences have been explored amongst a wider range of community mental health professionals (Norman and Peck, 1999) Yet differences of philosophy that may exist amongst professionals ostensibly from the same profession (for example psychiatric nurses) reflecting differing personal values and agendas that may affect team relationships and actions have not been as well explored. It appears that such differences can have a substantial impact on the functioning of the CMHT as this relates to policy implementation (King, 2001). However, what is less clear is the interpersonal content of these differences and their negotiation within the CMHT that determines team responses to policy (Swift and West, 1998).

3.2 CMHTs and policy compliance

CMHTs were expected to resolve many inter-agency and inter-professional ambiguities and tensions inherent within Government mental health policy in the 1990s, being charged with both providing services, acting as gatekeepers to services and maintaining public confidence in policy as agents of community supervision (Onyett, 1998). Test (1990) point s out that what mental health professionals choose to focus on determines whether policy

innovation is successful. If professionals do not view a policy as legitimate they will fail to co-operate in its implementation (Carrier, 1990). 'Professionals' in this context are usually identified in terms of clinicians yet within mental health services in the 1990s many managers were also former clinicians (Peck *et al.*, 1997). Therefore one may argue one needs to consider not just what practising clinicians chose to focus upon but also what their managers chose to emphasise to them in policy terms at this time. This is important as the relationship between clinical practitioners, operational managers and policy choices had to accommodate a UK policy environment that during the 1990s fluctuated between a commitment to community care and user empowerment with the management of user's deemed 'at risk'[9] that had professional and political dimensions.

Professionals' navigation of such policy fluctuations and the ambiguities/ contradictions that may arise as a result can influence practice responses and thereby the overall operational response to policy (Goodwin, 1997). For example, Bindman *et al.*'s (1998) survey of the implementation of the supervision register found that whilst 90% of Trusts in England had implemented written guidelines and a structure for the use of supervision registers, at the individual level, amongst those placed on the supervision register, the majority of patients neither had structured and detailed risk assessments nor did clinicians refer to the register as significant in their management of patients. In effect therefore central policy was complied with at the meso level but at the micro level was either ignored or only partially complied with.

Norman and Peck, (1999) considered four factors that appeared to underlie partial or non-compliance of CMHTs with policies such as CPA:

- Lack of faith in the operational system
- Strong loyalty to professional cultures
- Lack of a shared philosophy within Community services
- Mistrust of management derived solutions

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[9] See Chapter 2, Section 2.1

As far as commitment to national policy was concerned, Norman *et al.*, (1998) argued that practitioners perceived much mental health policy in the 1990s as a top down imposed system. They further argued, echoing earlier criticisms by Rogers and Pilgrim (1996), that this led to a lack of clarity with regard to who was the target population for CMHT intervention and, by implication, an inability to operationalise policy effectively because of ambiguities in roles and responsibilities (North *et al.*, 1993; Chandler, 1996).

Norman and Peck (1999) characterised these difficulties as focused around communication, leadership conflicts, lack of effective team management and poor role identification. This analysis appears to be supported by Øvretveit *et al.*, (1997), who found a lack of uniformity in the managerial arrangements governing CMHTs around the country with up to five operational forms of management structure. Work elsewhere demonstrated that even where management structures appeared formally settled questions of leadership as they related to CMHTs could remain contentious within teams and with operational management (Sims and Sims, 1993; Lucas, 1996). Such tense relationships it could be argued further hampered policy implementation since *authority* of leadership was not supported in the eyes of some within the CMHT by *legitimacy* of leadership

Norman and Peck (1999) argued for a clearer role identity and clarified management structure within CMHTs as a solution to these issues, yet as the above indicates structure of itself may only be a partial solution. They appear to have pursued with less vigour the question of the relationship between support for policy and its implementation. Yet some CMHNs and psychiatrists viewed the policy of community care as a threat to 'demedicalise' care thereby constraining and narrowing their role so as to reduce their status (Goldberg, 1986; Leff, 1997). It may also be argued that Norman and Peck (1999) did not appear to question policy fundamentals. For example, practice responses to community mental health policy, it was argued at the time, were due to untested assumptions around the concept of the CMHT itself (Galvin and McCarthy, 1994).

Norman and Peck's (1999) analysis locates policy implementation problems at the local level primarily focused on lack of clarity with regard relationships between practitioners

and management, resulting in conflicts around leadership and communication. Such analysis can imply that practitioners reject policy outright through non-compliance. However responses to policy consequent of such perceptions may lie along a continuum from absolute compliance to absolute non-compliance and reflect factors other than ones of conflict or ones related to poor management structures. Policy implementation along this continuum may reflect practitioners' attempts to 'manage' policy locally in relation to organisational and practice pressures, including levels of resource (Dopson, 1997) rather than an outright rejection as a means of registering disagreement.

As Norman and Peck (1999) indicate much interest in the operationalisation of mental health policy through the CMHT focused on tensions between operational management and professional autonomy. The focus in such cases was on the relationship between managers and clinicians in terms of why clinicians chose not to follow managerial precepts or the efficiency/ training of operational managers (Peck *et al.*, 1997). It would appear an element that is less often considered within the literature is whether managers chose not to emphasise certain policy precepts to the CMHTs within their organisations. For example, Atkinson (1996) argued that Supervised Discharge provided the basis upon which local authorities could be sued for lack of sufficient services to meet the mental health needs of an individual. Indeed, an in-patient attempted to do this in relation to the requirements of the CPA (Health Service Journal, 1996). Mental health agencies in the USA had been reluctant to implement similar provisions for fear of litigation (Fulop, 1995).

Managers in UK mental health services, concerned with conserving resources, may have been reluctant to encourage the use of such statutory instruments as Supervised Discharge because of their resource implications and have had some sympathy for practitioners who objected to its implementation. However, the need to be seen to be sensitive to public concerns and to support central policy meant that such support if it existed could only be tacit; serving to ensure that any questions regarding non-implementation were directed towards clinicians' rather than managers' commitment to policy.

3.3 Causes of stress and anxiety in CMHTs

The literature on stress and burnout amongst mental health professionals in general and CMHTs in particular is a well-developed one (Handy, 1990; Carson *et al.*, 1997). Stress, anxiety and emotional exhaustion are recognised factors amongst professionals working within CMHTs (Walsh and Walsh, 2001). Though their relationship to 'burn-out' appears more complex within CMHTs since a number of studies have found that these stressors can co-exist with positive job satisfaction (Onyett, 2003). The significant factor in relation to this appears to be the degree to which there is a strong identification with 'the team' and a clarity of roles within 'the team' (Borrill *et al.*, 2000). Such issues are associated with the degree to which teams and members within them subscribe to a common perception of focus and role.

As has been indicated, the policy rhetoric and pressure to focus on SMI during the 1990s came up against a range of difficulties on the ground and could be seen as in conflict with professional values of equity, universality and comprehensiveness (Wells, 1995). Norman and Peck (1999) argued that lack of a strong philosophical basis to underpin CMHT work meant that the process of care and the goals of the service lacked direct correlation at this time. Such a mismatch provided a context in which a tense working environment could develop.

The increased emphasis on the involvement of carers and users in clinical decision-making (Reith, 1998), combined with a professional commitment to holism, was potentially at odds with local and national policy and provided a context for inter-professional and inter-agency tensions. The organisational and managerial reconfigurations that occurred in the NHS in the 1990s were particularly marked in London and the South East of England, where Government inspired re-configurations, through the London Implementation Group, of mental health services were the most radical (Lelliot *et al.*, 1997), and added further difficulties and uncertainties within the policy implementation environment. A number of studies found that these changes appeared to particularly affect those working in the community, possibly because their own professional role and boundaries were in a state of

change (See for example Hadley and Clough, 1996). It is not surprising therefore to find that professional stress and 'burnout' were a focus of concern and study at this time.

Onyett *et al.* (1996) point out that Carson *et al.'s* (1995) study of stress and burnout amongst CMHNs found that 41% of their sample exhibited psychiatric symptoms associated with stress. Onyett *et al.* (1996) found that psychiatrists had the highest levels of stress in the CMHT. It was speculated that this was a consequence of psychiatrists' lack of personal relationships with users compared to other members of the team. Onyett (1998) found that psychiatrists felt they had overall responsibility for the CMHT but that their authority was inexplicit. Reith (1998) found that psychiatrists perceived themselves vulnerable to criticism if a user's care should prove controversial, though in reality they often had a low profile in terms of the criticisms of inquiry reports. Kendall and Pearce (1997, *cited in* Walsh and Walsh, 2001) found such concerns, combined with cultural and organisational changes, were a factor in the decision of psychiatrists to take early retirement.

In a study of the impact of organisational and legislative change wrought in community care, Hadley and Clough (1996) interviewed a range of practitioners (Social Workers, CMHNs, Psychiatrists etc.) and found:

> "For almost all the people we interviewed the experience of change has been one of loss: the loss of being valued, the loss of having clear purpose and hope in the future, the loss of enjoyment and, for some, the loss of a career."
>
> (Hadley and Clough, 1996, p176)

Hadley and Clough (1996) found mental health practitioners reported high levels of stress as a result of increased workloads leading to frustration and alienation from their work, management and organisations.

Professionals in the community were preoccupied with security of employment. Staff fears for their jobs were based on their perception of the high turnover of managers and apparent job cutting amongst this group. For example for the financial year 1996/1997 the

Government demanded that NHS trusts reduce their management costs by 5% (Butler, 1996c). This fear was reinforced when some professionals reported to colleagues that they had actually been threatened with redundancy if they did not perform as required (*ibid*). Other studies confirmed this relationship of stress with operational tension and low morale (Onyett *et al.*, 1996).

Onyett *et al.* (1996) argued that the policy dictated focus of CMHTs' work on those with the most complex of needs, without a commensurate increase in resources and clarification of policy goals and inter-agency working created an environment in which morale was likely to suffer. The position of the CMHN within the CMHT appears to encapsulate the effects of these issues.

3.3(a) Skills acquisition as a means of alleviating personal stress and clarifying roles

As indicated earlier, the most significant professional group within the CMHT in terms of numbers within teams were CMHNs. The Sainsbury Centre for Mental Health (1997) noted that CMHNs had low morale resulting from the interaction of an inexplicit role within the CMHT, professional rivalries, low pay and low status. Rogers and Pilgrim (1996) argue that CMHNs felt threatened with de-professionalisation as a result and therefore were busy collecting further skills to justify their position. This thesis, however, seems somewhat simplistic and prejudiced in that it judges the acquisition and enhancement of a skills base within mental health nursing differently from similar activities undertaken by other professions in the CMHT.

It may be argued that the increased demand for training in psychosocial interventions for community practitioners with individuals with schizophrenia and their families, for example the Thorn initiative (Jackson, 1998), was more concerned with managing those identified as the "at risk" group, - SMI. The willingness of NHS trusts to fund staff to enter this training and the demand for it, particularly amongst CMHNs, can be seen as a means of practitioners managing their own stress in relation to interacting with this group and the potential political and professional threat they had come to represent to the clinicians sense

of professional security from criticism. Therefore, post registration skills acquisition may be seen as an adaptation to a change in the focus of the work environment in which CMHNs operated (Norman *et al.*, 1996) rather than as a means to justify their professional existence within the CMHT.

Such responses are understandable when one considers that the Department of Health required an inquiry be held in all cases of homicides involving a mentally ill person (Department of Health, 1994) and that inquiries are it is argued often concerned with apportioning blame (Reith, 1998; Stanley and Manthorpe, 2001). In combination with fears about employment security, it may be argued that a culture of professional vulnerability will arise. This sense of vulnerability is likely to be exacerbated where the nature of one's role is either ill defined or develops in an ad hoc fashion, as was the case with CMHNs (Repper, 2000). For example, Onyett *et al.*'s (1996) study of practitioners in 57 CMHTs found that role ambiguity played a significant part in the stress levels of practitioners. Forty-five percent of CMHNs were found to suffer from high emotional exhaustion. This finding was supported elsewhere (Carson *et al.*, 1995).

Post-registration skills acquisition may in fact serve to clarify roles for individuals within a context of ambiguity, and thus reduce stress. Work by Hannigan *et al.*, (2000) indicates that CMHNs with post-registration qualifications had a higher sense of self-worth than those without. In this sense Rogers and Pilgrim's (1996) observation has some validity.

3.3(b) CMHT membership as a source of support and stress

Galvin and McCarthy (1994) point out that the lack of clear aims, roles and responsibilities within CMHTs serve to diffuse personal accountability. The importance of the 'team' and locating accountability to operational management within it therefore may have served at this time to alleviate personal stress through maintaining this diffusion (Onyett and Ford, 1996). This appears particularly important when practitioners have to deal with dilemmas posed by limits on resources (Onyett *et al*, 1996). Studies on 'burn out' seem to demonstrate practitioners in teams that are supportive and have a strong sense of identity

tend to suffer from less stress than others (Onyett *et al.*, 1996). Thus the importance of team membership may outweigh other considerations because of personal costs associated with being outside the team.

The CMHT also provides a forum for self affirmation through day to day working and co-operative casework (Øvretveit, 1995). This affirmation process serves to construct and maintain role identities within the CMHT through socialisation and interaction (Norman and Peck, 1998). Thus the practitioner is socialised in team values and *ways of doing* that serve to emphasise the importance of team cohesion (Øvretveit, 1995; Wilmot 1995).

However, CMHT membership may be important to some more than others. For example, Mistral and Velleman (1997), in a survey of the views of the members of 17 CMHTs found that Psychologists were the least favourably disposed professional group to the concept of the CMHT as a context for professional working and felt that the CMHT was professionally isolating. Alternatively, CMHNs tended to disagree with the idea that CMHTs were professionally isolating.

The level of importance and commitment to the concept of team membership may be gauged to some extent by the amount of time an individual professional devotes to working through and within the team. Onyett *et al.* (1994) in a survey of CMHTs in 1993, found that only CMHNs, Social Workers and Occupational Therapists worked on average more than four days per week within the CMHT, whereas Psychiatrists and Psychologists devoted less time to team working.

A number of changes within the paradigm of practice may have served to enhance team identification during the 1990s. The concept of key working (Gupta, 1995), with its emphasis on a form of responsibility for patient management which was functional rather than based on role or status potentially prompted a socialisation process that moved away from a uni-disciplinary focus to one located within the CMHT; encouraging relationships between individual practitioners and team colleagues to assume a greater importance than

those with members of one's own profession. In addition, the sense of siege and devaluation engendered by media and political pronouncements about the failure of community care, particularly from the mid 1990s onwards (Crepez-Keay, 1998; O'Rourke, 1999) and the public criticism of personal and team practice when there was a failure of care may also have served to bond the members of CMHTs (Stanley and Manthorpe, 2001), as a means of coping with a context of professional/personal stress and anxiety.

CMHTs, however, could be an arena for inter-professional conflict and consequently a source of individual stress (Norman and Peck, 1999). Practitioners' membership of the team and their profession was found to lead to a conflict of values between a community mental health philosophy that emphasised egalitarianism, the blurring of roles and a sharing of decision-making on the one hand with a reluctance on the part of members of the team to give up traditional, role definitions, authority and practices on the other (Onyett *et al.*1996; Owen, 2001). This led to struggles for power, most famously between psychiatrists and psychologists (Norman and Peck, 1999) but also between other professionals. For example, CMHNs and Social Workers in the 1990s appeared to be engaged in a degree of competition; with CMHNs apparently favoured in policy because they had a tradition of accepting medical authority (Beattie, 1995).

Whilst it appears clear therefore that operating in community mental health in the UK was stress inducing, Walsh and Walsh (2001) counsel against taking the findings of many of these studies at face value. They argue that the majority of investigations tended to rely on self-report questionnaires. Apart the ambiguities resulting from individual interpretation of questions and the limited number of responses imposed upon respondents, Walsh and Walsh (2001) argue that such surveys potentially underestimated particular areas that might cause stress, for example personal contact with patients, because respondents may have deemed it professionally unacceptable to admit to difficulties in such areas. However, the issues identified within the literature as causing tension and stress do seem to have a common thread - the degree to which professionals could feel confident in their professional autonomy and exercise of discretion.

This last issue points to a conundrum for Government in terms of mental health policy implementation. Because of the private nature of the clinician/user relationship Government is often reliant on clinicians to self-report on their implementation of mental health policy. This position arises largely as a result of a traditional social and organisational acceptance of clinical autonomy and the employment of professional discretion in relation to the care of the individual patient. Therefore, the need to influence discretion and limit autonomy is an important issue for Government in relation to ensuring policy implementation.

3.4 Autonomy, discretion and the members of the CMHT

The autonomy of mental health professionals, and psychiatrists in particular, was identified in the 1990s as problematic in the management of mental health services (Peck, *et al.*, 1997). A number of inquiries into violent incidents involving patients living in the community called into question their professional ability and clinical judgements in relation to risk (Reith, 1998). The degree of negative publicity for Government policy that resulted from the findings of these enquiries emphasised the potential political consequences to Government resulting from clinicians' decisions. Thus, clinical discretion needed to be curtailed and shaped to meet government priorities and "control" the political aspects of its exercise. This was even more urgent once the move from institution to community had led to a diffusion of practice in which the semi-professions in mental health (for example, mental health nursing and social work) were also given or received by default a degree of discretionary competency that they previously lacked (Morrall, 1997).

The dilemma for Government in the 1990s was and remains two-fold. Firstly, any attempt to interfere directly in clinical discretion at an individual level is seen as illegitimate and likely to evoke negative political consequences. Secondly, implementation of mental health policy relies on the flexible exercise of professional discretion, as the nature of the psychiatric user group is inherently unpredictable. The Government's solution to this dilemma was to attempt to change the premises of clinical decision making as a means of

increasing its influence on practitioner actions whilst retaining clinical flexibility. Government utilised a number of mechanisms to achieve this.

One such mechanism was to reduce and focus spheres of discretion by making practitioners more accountable for their decisions. There were two forms within mental health services that this took. The first was "steering" clinicians through general parameters rather than detailed prescription. Thus guidelines as to practice and general statements around mental health priorities were issued. For example, leaving local trusts, in consultation with commissioners, to produce CPA criteria, who then relied on local clinicians to interpret these aims (Tuohy, 1999), or *recommendations* to use of the Health of the Nation Outcome Scales (Wing *et al.*, 1995).

However, such an approach had unintended consequences, such as task displacement. For example, Brooker and White (1997) found that whilst there had been a practice shift on the part of CMHNs towards meeting the government priority of carrying a larger caseload of SMI, this had been at the expense of older people with dementia or mentally ill adolescents, unless these groups met locally set SMI criteria (Brooker and White, 1997). Consequently, two groups that were strongly "politicised" – the elderly and children - were not receiving services.

The second mechanism employed was a retrospective control through the collection of output data at local level. This could be used to reward or sanction workers according to their degree of policy compliance. The motivation to collect and report such data appears to be based upon the inter-dependency of two dimensions. The first is responsibility, that is that which an authority can require a of a member of staff. The second is accountability, that is the relationship that exists between a member of staff and their employing authority in terms of answering for what they do. Yet the weakness of this approach was that it still largely relied on the self-report of clinicians.

These methods of controlling discretion relied on a link between following procedures, reporting on compliance and being held accountable for non-compliance. Their weakness was a 'tautological' one - procedures to control discretion relied to a large extent on the practitioner's discretion to report upon their actions honestly. Bearing in mind that it was the clinical area that contracts and policies were meant to affect practitioners were placed in a powerful position to manipulate data so as to appear to be complying when this may not have been the case (Schneider, 1993). Indeed the weakness of systems was implicit in the focus of commissioners and managers on reporting systems, such as regular meetings between GPs and CMHTs, forms of referral (Sledge, *et al.*, 1995) and broadly articulated clinical standards (Department of Health, 1995b) rather than the inter-change between user, practitioner and team. Therefore, some other means of controlling discretion was also needed. This was to persuade practitioners to internalise Government concerns within their personal and professional frame of reference when making discretionary decisions. In this context the rhetoric of 'risk' was increasingly employed during the 1990s.

3.5 Internalising the rhetoric of 'Risk' within clinical practice

Beck (2000) states, "Believed risks are the whip used to keep the present-day moving along at a gallop" (p.214). Douglas and Wildavsky (1983) argue that an interest group may consciously create perceptions of risk as a means of setting and controlling an agenda. During the 1990s the language of mental health priorities, both in offical publications and the literature, increasingly focused on "risk" assessment and containment of patients deemed "difficult" and "at risk" (Department of Health, 1993; Department of Health, 1996a; Brooker and White, 1997). Indeed, consequent perhaps of public anxieties about community care policy, the way 'risk' was conceptualised by central Government underwent a change away from seeing it primarily in terms of self-harm, as it was conceptualised in one of the earliest editions of *The Mental Illness Key Area Handbook* (Department of Health, 1993a) to one which emphasised the threat posed by an individual to harm others, (Department of Health, 1994a and b; Department of Health, 1995b).

The introduction of supervision registers, Supervised Discharge and the tiered approach to CPA all in one way or another served to emphasise the clinician's responsibility to manage risk and to conceptualise it primarily in terms of harm to others or, as the Secretary of State for Health at the time (1994) put it, 'serious adverse events'. The policy emphasis on team working, inter-professional working and inter-agency collaboration also effectively focused on managing risk in terms of potential for harm to others (Department of Health, 1997).

The importance attached to working with SMI rather than the 'worried well' meant that mental illness prevention was a secondary strategy in as far as it promoted the minimisation of 'risk' behaviour and thus was not an end in itself (Wells, 1998). The manifestation of this change in a practice context can be seen in the terms of reference of the Viner Report, an inquiry into the circumstances leading to the murder of Murial Viner by her son, Robert, a user living in the community and his subsequent suicide. This report emphasised psychiatric assessment in terms of the relationship between previous psychiatric history, the potential for harm to others and previous court convictions rather than on Robert Viner's potential for self-harm (Harbour *et al.*, 1995).

- Young men
- Aggressive and or perceived as dangerous
- Multiple problem behaviours that appear non-responsive to intervention
- Non-compliant with medication
- Psychotic illness
- Those labelled "troublesome"
- Physical problems
- Learning difficulties and resultant disturbed behaviours
- Persons who are a risk to themselves

Box 3.3
Patients "At Risk"
Adapted from Trieman (1997)

Trieman (1997) refined the central policy concern with "risk" into a profile of the sort of patient that should be seen as "at risk" (Box 3.3). The guidance of policy also emphasised that public concerns were a legitimate consideration within clinical decision-making

(Department of Health, 1995a). This was a change from the past where such a consideration was only considered legitimate in cases involving a forensic history. Thus in *Building Bridges* (Department of Health, 1995a) there is a recommendation that practitioners, when conducting a comprehensive assessment, should consider local press reports about individuals and public attitudes.

It is well known that psychiatrists are poor at predicting risk of suicide (Gunnell and Frankel, 1994) and violence (Monahan, 1994). However, it has been found that psychiatrists have a tendency to over-predict dangerousness (Rose, 1986). Thus the contextual emphasis on 'risk' that took place in the 1990s was more likely to encourage a culture of 'risk policing' since the most influential clinical audience that received this message were already professionally cautious in their management of patients. This may well have encouraged the application of a label of "at risk" to more mentally ill individuals than perhaps their behaviour might have warranted, especially if individuals took a contrary stance to their clinician's opinions about their management or attempted to be assertive within the patient/professional relationship (Repper and Perkins, 1996). For example, Bindman *et al.*'s (1998) survey of the implementation of supervision registers found that more patients were placed on the supervision register because of a fear they would harm others than for fear of self-harm or self-neglect.

The establishment of a practice culture of 'patient risk management' could be seen to have established a focus of tension amongst the members of a CMHT and between the CMHT and local management. Reith (1998) states, "Being able to assess risk and then to manage it successfully is fundamental to community care" (p131). This statement is indicative of the degree to which the notion of "risk" came to lie at the heart of community care. What is also significant in this statement was the need to be seen to "manage it successfully".

Lash (2000) points out that a cultural mindset based upon notions of risk "start not from the risk but from the blame, start from the 'who to blame'." (Lash, 2000:51). Thus for practitioners in community mental health "risk management" may not only be associated

with the threat the user's behaviour poses to others or their own well-being, but may also be associated with the personal and professional consequences for the practitioner that are implied should users engage in activities that cause public difficulties for management and Government. Therefore, by implication, risk management may require practitioners to engage in defensive practice with regard to users, involving self-censure of their discretion to allow/ encourage the user to 'take risks' (Marks *et al.*, 1994).

3.5(a) The 'gradient of danger', insecurity and 'Governmentality'

Thus Government established a rhetoric of risk, associated with 'dangerousness', within community mental health services and practice paradigms. Cooper (1990) argues that in such an environment managers and practitioners operate on a "gradient of danger", that is the degree to which they perceive their working environment and those they work with as threat. This perception of threat leads them to demand clear-cut structures, lines of responsibility and accountability. Such structures provide a degree of reassurance to both policy makers and practitioners alike (Cooper, 1990). Concerns about lack of structures and focus within CMHTs, combined with calls for their redress (See Section 3.2), need to be seen in this normative light. Awareness of this gradient of danger can also lead to a cautious attitude to both innovation and change (Cooper, 1990). The objective of care it may be argued then becomes limiting the number of incidents of dangerousness, such as suicide or homicide (Wells, 1998).

Blau (1963) noted that in an environment of insecurity, risk avoidance becomes an abiding feature of practice, yet the achievement of policy objectives within personal services often involves an element of risk taking. Therefore, it is possible that practitioners will abandon the therapeutic objective if they perceive it as in their best interests to do so. Thus, within community mental health practice there was established a conflict between a professional philosophy that emphasised independence and maximisation of social functioning, with operational resource limits and policy demands that emphasised assessment in relation to the "policing" of risk (Ramon, 1985). Indeed, the assessment and management of risk was now seen as fundamental to the success of community care (Reith, 1998).

These issues relate to Foucauldian ideas on the control of a population through problematisation and regulation of social life (Turner, 1997; Petersen, 1997). The mechanism through which this is done is known as 'Governmentality', in which professional authority is constructed to enforce standards of conduct (Rose, 1993; Jack, 1995; Osborne, 1997). Thus the rhetoric and construction of 'risk' within mental health in the UK during the 1990s may be conceptualised in terms of constraining and re-constructing the authority of mental health professionals through problematising one group of users, those diagnosed as SMI. This, it may be argued involved replacing one set of professional values, for example maximisation of social function through empowerment (Oliver *et al.*, 1996; Sayce, 2000) with another - risk containment and management – in which social function of individuals identified as SMI was to be monitored and controlled (Rose, 1996; Turner, 1997).

The mechanism through which this was achieved is what Foucault terms the "clinical gaze", that is the process by which an individual is transformed into an objectified entity, with a focus on one part of his/her totality – in this case risk. Limits upon professional choices and freedom of action may have been achieved through requiring the CMHT to manage personal and professional anxiety, within a context of the ambiguities of local and national policy, by defining who was their primary client – the patient or those affected by his/her behaviour, with particular reference in this instance to management and Government pronouncements.

3.6 Conclusion

A review of community mental health policy development during the course of the first half of the 1990s raises a number of issues in relation to the way it was received and implemented at local level. Policy appeared to be underpinned by principles of fiscal and risk containment. A central Government emphasis on tight resource restraint combined with a rhetoric of reassurance to the public in relation to the management of people with mental illness in the community created a context of ambiguity and operational pressures for management and clinicians at local level, for example defining SMI users. This situation

was further complicated by the position of GP fund holders in relation to the purchasing of services and a Government emphasis on accommodating their needs.

The political concern about public perceptions of mental health policy combined with a lack of clarity surrounding policies such as supervised discharge and a lack of resources for implementation raises the question whether some mental health policy had a more symbolic rather than practical purpose at this time. This in turn raises the question as to whether there was a serious intention on the part of Government to see such policies implemented at local level (Bressers *et al.* 2000).

In such circumstances a myriad of questions are raised in relation to local implementation of national policy. For example how did local implementers make sense of ambiguous and contradictory policy? To what degree was internalization of policy rhetoric significant in determining implementation decisions; in particular which policies were local managers and practitioners most concerned with and why? To what degree was implementation of policy affected by local dissent? Certainly, the sluggishness of CPA implementation suggests a policy resistance as a significant local phenomenon. Did all professionals and managers at local level share the same view of the policies with which they were involved and have similar priorities? For example, mental health professionals such as CMHNs were told by central policy to prioritise people with severe mental illness whilst their social worker colleagues were more focused on issues of child protection (Muijen and Hadley, 1995).

Consequently, one is left to ask what were the results of these policy questions at local level in relation to overall implementation of central policy? In effect, this question relates to the degree that policy rhetoric at national level is internalized at the local level and what affect this has on relationships, perceptions and actions with regard a continuum of policy compliance and implementation at the micro level. An exploration of relevant theoretical work and its application to this last question may help to clarify specific issues that need to be examined if one is to be in a position to answer this question.

CHAPTER FOUR

Policy, Implementation And Community Mental Health Services - Exploring Theory and Concepts

4.0. Introduction

One of the standard American texts on mental health policy, David Mechanic's 'Mental Health and Social Policy', (Mechanic, 1999) which is now in its fourth edition, makes no attempt to operationalise the term 'mental health policy'. Neither, more recently, does a Maudsley monograph guide to the development of national mental health policy (Jenkins *et al.*, 2002). Rather, in both works there is a presumption that readers both understand and have a shared understanding of that term with the author/s. Yet the way a writer interprets the meaning of the term 'policy' may very well lead to certain issues being highlighted over others without the reader being aware of this (Rochefort, 1993).

The purpose of this Chapter is to operationalise the term 'mental health policy' and 'implementation' as these were used within this study to inform the conceptual framework that was developed to facilitate the examination of policy and implementation issues at a local and micro level. Thereby the reader may be alerted to factors that influenced data selection, interpretation and emphasis. The initial considerations in defining policy and implementation are discussed in Section 4.1.

In Section 4.2 the literature on the theory of policy development in mental health is briefly surveyed, where it is highlighted that explanatory and theoretical frameworks often fail to consider the influence of lower or 'street' level of policy implementation in mental health settings. The case for the development of multiple levels of analysis when seeking to

understand the relationship between policy and implementation at local level is then examined in Section 4.3.

Section 4.4 examines the context in which decisions are made by implementers through a consideration of attempts to place ' economic man' (Roberts, 1989) and the management of uncertainty (Cropper and Forte, 1997) at the heart of clinical decision-making in the NHS during the 1990s. Finally, it is argued in Section 4.5 that an analysis that aims to consider issues of mental health policy implementation at local level therefore needs to incorporate this issue within its framework.

4.1 Defining policy

A dictionary definition of 'policy' is "a plan of action adopted or pursued by an individual, government, party or business" (Collins, 1999). However, this definition fails to communicate the complexity of its nature in terms of development, process, impact and experience. For example, Carpenter (2000) in a comparative review of the sociological literature on the development of mental health policy in the UK, USA and Europe, argues that mental health policy is shaped by an interactive relationship between *external* and *internal* socio-political forces.

Social and political scientists have tried to accommodate these issues within multiple definitions of the policy phenomenon. Thus Reading (1978) identified three meanings attached to the word – the aims and course of action followed by governments, groups or individuals; general rules guiding decision-making and organisational rules limiting discretion of subordinates. Whilst Reading (1978) places an emphasis on following some form of plan in his definition, others such as Pressman and Wildavsky (1984) and Spicker (1995) place greater emphasis on policy origins, goals, the process of implementation and outcomes. Pressman and Wildavsky (1984) argue that a policy must specify not only goals and outcome but must also specify actors and actions if its implementation is to be understood and capable of study.

Policy Type	Definition	Significant Stakeholders/ Actors	Areas for Examination
1.POLICY-IN-INTENTION	1.a) Policy is an assertion of intents or goals	Legislators, local administrators and agencies	Outcomes
	1.b) Policy is the accumulated standing decisions of a governing body by which it regulates, controls, promotes, services and otherwise influences matters within its sphere of authority		Rules
	1c) Policy is a guide to discretionary action		Guidelines
	1.d) Policy is a strategy undertaken to solve or ameliorate a problem		Sets of tactics
2. POLICY-IN-ACTION	2.a) Policy is sanctioned behaviour, formally through authoritative decisions, or informally through expectations and acceptance established over (sanctified by) time		Expectations and behaviour
	2.b) Policy is a norm of conduct characterised by consistency and regularity in some substantive action area	Local managers, street-level bureaucrats	Norms
	2.c) Policy is the output of the policy-making system: the cumulative effect of all the actions, decisions, and behaviours of people who work in bureaucracies. It takes place and is made at every point in the policy cycle from agenda setting to policy impact		Effects
3. POLICY-IN-EXPERIENCE	3.a) Policy is the effect of the policy-making and policy implementing system as it is experienced by the client.	Legislators, managers, client	Encounters

Box 4.1 Guba's Policy Analysis Domains (Guba, 1984)

Guba (1984) identified eight definitions of 'policy', ranging from an assertion of intent through to a strategy to ameliorate a problem, or the experience of clients of the policy implementing system, organised under three broad categories (Box 4.1). He argues that there is no one single definition of policy; all are constructions that reflect value choices. However, Guba (1984) does argue that the choice of definition has consequences for policy analysis in terms of its effect on process, that is what is not looked at as a result of definitional choice, and thereby affects both outcomes and how these are presented. In this regard we therefore need to understand its relationship to the term *implementation*.

4.1(a) Defining implementation

'Implement' means 'to carry out or put into action'. As a noun it has two meanings, it can mean a *tool* or *a means to achieve a purpose* (Collins, 1999). From this it may be seen that the word *implementation* carries within it notions of process, purposeful activity and the means of achievement. It is inextricably linked to the concept of policy, since a policy goal maybe the purpose to be achieved through implementation, but policy may also specify the process of implementation.

These inter-related concepts and issues are well illustrated in the classic study on implementation of an employment policy by the Economic Development Administration in Oakland, USA during the 1960s by Pressman and Wildavsky (1984). For them implementation is 'a process of interaction between the setting of goals and the actions geared to achieving them' (Pressman and Wildavsky, 1984: xxiiii). They believe it is inextricably bound up with the interrelationships between agents and individuals who carry out policy actions.

Their interpretation is encapsulated within the concept of *complexity of joint action* (Box 4.2) in which ends and means are inextricably inter-related and in which different 'actors' interpret policy differently. Thus the process of implementation involves negotiation and coercion between different individuals and agents to achieve their interpretation of means, ends or both. Pressman and Wildavsky (1984) appear to take a pessimistic view of successful policy outcomes (i.e. that the policy successfully

achieves its intention) because of this process of re-interpretation (See also Dimitrakopoulos and Richardson, 2001, for a discussion of the process of re-interpretation).

- Direct incompatibility with other commitments
- No direct incompatibility, but a preference for other programmes
- Simultaneous commitments to other projects
- Dependence on others who lack a sense of urgency in the project
- Differences of opinion on leadership and proper organisational roles
- Legal and procedural differences
- Agreement coupled with lack of power

Box 4.2
Complexity of joint action
(Source: Pressman and Wildavsky, 1984)

Allison and Zelikow's (1999) analysis of the Cuban Missile Crisis through the prism of three policy decision making models (Box 4.3), of which, for the purposes of this study, Model II – Organisational Behaviour- and the group processes element of Model III – Governmental Politics- provide some useful insights in relation to implementation. The first model indicates the level of rational calculation, which may exert an influence on decision-making, particularly in relation to maximising outcome. However, the other two models indicate that decision-making is rarely based on rational calculation alone, particularly when it takes place within the parameters of a group setting and is affected by intra-organisational and external influences. Of note in Model II is the influence of organisational rather than external priorities on implementation and that implementation reflects previously established routines.

This may help to explain in part why both CPA and Supervision Registers were implemented in such a desultory way in spite of the high priority they received from central Government.[10] Equally, Central Government's emphasis on developing the use of information systems can be seen as attempting to change the behaviour of implementers such as local managers and clinicians.

[10] See Chapter 2, Section 2.4 and 2.5

MODEL I – Rational Action:

- A ranking of goals and objectives;
- A range of differentiated alternatives from which a choice can be made;
- A set of consequences attached to each alternative choice;
- A choice of an alternative whose outcomes are likely to achieve the highest ranked goal/ objective.

MODEL II – Organisational Behaviour:

- Existing organised capabilities influence government choice;
- Organisational priorities shape organisational implementation;
- Implementation reflects previously established routines;
- There is often a gap between what is envisaged in a plan and actual implementation;
- There is limited flexibility and incremental change;
- Long range planning becomes institutionalised and then disregarded;
- Organisations define their 'health' in terms of their level of autonomy and span of control;
- Careful targeting of major factors that support routines –such as rewards and information –can affect major change within an organisation over time;

MODEL III – Governmental Politics (Group Processes and effects on choices and action):

- Multi person analysis and information can produce better decisions by ensuring thorough analysis or poor decisions because too many people analysing too much information produces analysis paralysis;
- The 'Agency ' problem: too many principals, agents and players can lead to competing objectives and asymmetric information;
- The background and role of each participant in a group decision affects the choice made;
- Decision rules within a group affect group choice;
- The way a problem is framed and reaches the group's agenda often affects how the group responds;
- There is a psychological drive for consensus in small cohesive groups that tends to suppress dissent and consideration of alternatives (Groupthink);
- The more institutions and agents whose co-operation or consent is needed multiply the more likely is that the original intent of a policy will decline (Complexity of joint action)

Box 4.3
Three decision-making models
(Allison and Zelikow, 1999)

Model III's emphasis on the informal influences at play within a group when it attempts to make a decision, for example the relative status of group members, the importance of how a problem is presented and the consensus imperative that appears to operate within small groups also has relevance when one is considering the nature of CMHTs as outlined in Chapter 3, particularly in relation to the relationship of practitioner identity

with the CMHT and CMHT membership as a source of both individual stress and support.[11]

Supportive Context

- Circumstances external to the implementer must not impose crippling constraints
- Adequate time and sufficient resources must be made available to the programme
- The required combination of resources must be actually available

Clarity of purpose

- The policy to be implemented must be based upon a valid theory of cause and effect
- The relationship between cause and effect must be direct and there must be few, if any, intervening links
- Tasks must be fully specified in the correct sequence

Agreement on complimentary action to achieve one purpose

- Dependency relationships between implementing agencies must be minimal
- There must be complete understanding of and agreement on objectives throughout the implementation process
- There must be perfect communication and co-ordination between participants
- Those in authority must be able to demand and obtain perfect compliance

Box 4.4
A modification of Gunn's ten pre-conditions for successful implementation
(Gunn, 1978)

Gunn (1978) drawing from the literature identified ten pre-conditions for successful implementation (Box 4.4), which in turn may be organised under three inter-related headings of a supportive context, clarity of purposes and agreed action amongst the stakeholders to achieve one the policy goal. The utility of such a framework is not as a guide to successful implementation but as a means of analysing why implementation fails. It also provides a framework in which issues of a wider context can be related to issues of a local and individual nature.

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[11] See Chapter 3, Section 3.1a Section 3.1b

Indeed, the nature of the relationship between the individual actor and the implementation process is increasingly seen as an important area for policy analysis. This relationship is described by Ostrom (1999) as an *action arena*, which she defines as the social space in which actors engage with one another. Ostrom (1999) argues that implementation analysis at this level often neglects the cognitive, affective and motivational structures employed by individuals with one another, taking these as givens. She argues that an effective analysis of implementation at local level needs to specify these variables. This position receives support from Zerubavel's (1999) work on cognitive sociology, who argues that a significant motivator of individual action are the range of 'thought communities' that actors find themselves relating to at any one time.

4.1(b) Conclusion – relating actors to the wider context within implementation

Pressman and Wildavsky (1984) argue that policy goals and policy implementation are interactive and difficult to separate, particularly when policy involves a range of agencies and actors in what they term the 'complexity of joint action', which exercises a transformative influence on macro policy at the local level through the number of decision points that a policy passes during implementation (Katz and Danet, 1973; Majone and Wildasky, 1979). Michael Hill observed an "examination of the implementation process must be concerned with the nature of policy, and the inter- and intra-organisational context within which it is expected to impact" (Hill, 1997:132). Thus one can see policy activities as an inter-related dynamic between levels (Brodkin, 1988) that can only be fully comprehended through a consideration of local institutional and individual contexts and their relationship to the wider environment.

Yet studies of policy within health care sometimes fail to examine the inter-relatedness of this dynamic. For example, Dopson (1997) argues that there is little analysis of social structural processes in the NHS, with technological determinism figuring strongly in health care policy studies. The traditional areas highlighted in mental health analysis are stakeholder interests, distribution of resources and associated pressures or improvements in medical technology (Busfield, 1986; Scull, 1977; Jones, 1993). Debate often focuses on the content of policy rather than on the actors, processes and contexts in which policy occurs and is implemented (Ostrom, 1999). However, as a number of

writers have pointed out it is the dynamic of attitudes and emotional reactions at this 'micro' level that determines whether policy is implemented as policy makers intended (Smit, 2003; De Clercq, 1997). Thus analysis may need to go beyond the organisational and institutional to the relationship of policy processes, individuals and reflexivity at the 'street level' point of implementation, and the degree to which they are involved in not only implementing policy but also re-formulate it.

Within the field of community mental health, with its emphasis on personal relationships and team working, these issues are particularly relevant as the relationship between policy and implementation is symbiotic and may need to be examined at many textual/ individual levels. The established theoretical work on policy formulation and implementation in mental health will be examined next.

4.2 Established approaches to the study of mental health policy

The theoretical construction placed on mental health policy can take a number of forms. Scull (1977), adopting a Marxist perspective, sees mental health policy as primarily driven by capitalist concerns to contain, at minimal cost, individual and group deviant threats to the labour market. Banton *et al.*, (1985) locate it within a socialist framework of the interaction of ideology and the exercise of power. Goodwin, (1990), utilising a critical theory perspective, sees the development of mental health policy as a product of systems dysfunction between economic, political and social capital in which there is a crisis of legitimation. Alternatively, Jones (1993) and Sumathipala and Hanwella (1996) discuss mental health policy in terms of a positive evolution, drawing from the progressive policy model. A common theoretical construct is to view mental health policy in terms of a cyclical process oscillating between policy activity and stagnation or advance and retrenchment (Rochefort, 1993).

Bartlett and Wright (1999) amongst others (Cook and Wright, 1995) point out that until quite recently such studies of the development of mental health policy primarily focused on the rise and fall of institutional settings (Foucault, 1965; 1973; Jones 1993; Scull, 1977; Pilgrim and Rogers, 1999). Even studies that focus on community care can characterise it as a policy adjunct or development from the institution (See for example,

Goodwin, 1990; Mechanic, 1999), rather than consider it as a factor in the organisation and delivery of care that has a degree of continuity independent of the institution. Yet as writers such as Porter (1987) have indicated the historiography of mental health is more complex than the institutionally focused account allows for, with the majority of the mentally ill not cared for in institutions but indeed in the community, even at the time of the pinnacle of the asylum movement in the 19th century (Bartlett and Wright, 1999). Welshman (1999) develops this further by pointing out that whilst there were statutory and voluntary community services for the mentally ill since the 19th century, it was only from the 1950s that they received policy emphasis.

It may be argued that the dominance of institutional modes of thinking in interpreting mental health policy and its politics has led to an incomplete understanding of mental health policy development, formulation and implementation, emphasising some influences whilst ignoring others. For example, Cavadino's (1991) study of the 1983 Mental Health Act almost completely focuses on the operation of mental health law within the context of institutions and detention, largely eschewing an examination of the operation of the law as it affects people cared for in the community. Yet at this time there was already a strong policy emphasis in the UK on community care.

The emphasis on the idea that social control and surveillance transferred from the asylum to the community is an example of the influence of this institutional focus on conceptions of mental health policy theory. This thesis, which has increasingly attracted support (See for example, Morrall, 1998), appears to draw its theoretical inspiration from Foucault's notions of surveillance and control, developed, in part, from his study of the growth of the asylum in France and the social role of medicine (Foucault, 1965; 1973). Yet an alternative perspective could be that the emphasis on the care of those with SMI empowers users through the allocation of intensive support to live in the community, providing them with the necessary resources to make a success of their life away from institutions (Wells, 1998).

If one looks at the work of Busfield (1986) one may see how the institutional emphasis in the study of mental health policy affects theoretical constructs to explain policy

development. Busfield's (1986) discussion of the development of mental health policy in the United Kingdom follows the trajectory of the rise of the asylum and then the development of community care, which, for her, primarily develops during the 1930s and in the post-war period. The focus on institutions tends to lead to a discussion of the influence of the professions that work in those institutions and, particularly those who are seen to lead them, the medical/ psychiatric profession. This group figures strongly in Busfield's (1986) account of the development of mental health services and community care. Indeed she appears to see the relationships between this group and the State as the primary determinant in the development of mental health policy.

Such an account as that proposed by Busfield (1986) fails to consider the interplay and influence of groups traditionally not identified as institutionally powerful. Thus the influence of other professions such as nurses, social workers, carers and patients are not considered as significant in the overall account of policy development. Where they are examined (See for example Nolan, 1993) accounts consider these groups largely in isolation, rather than recognising their interconnectedness and co-dependency.

Perhaps because of this institutional focus, studies have tended to focus on policy development at a macro level. However, as Welshman (1999) points out little is known about the ways policies develop and are implemented in community mental health services at local level. The emphasis in mental health on team working and inter-agency collaboration in recent years emphasises the need for such issues to be incorporated into explanatory accounts of mental health policy.[12] In order to address some of these issues the development of a conceptual framework that examines national and local mental health policy and the attitudes, responses and relationships of local implementers' to community mental health policy in their interpretation and implementation is needed to guide exploration.

4.2(a) Exploring policy-making and implementation perspectives in mental health

Mental health policy, it has been argued, encompasses macro and local politics as they relate to priority setting, policy implementation and the actions/ devices necessary to

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[12] See Chapter 2, Section 2.2

facilitate implementation (Tudor, 1996). Grob (1994) and others (for example, Williams, 1988) emphasise that mental health policies are often the product of the prevalent opinions and values of the public, politicians and professionals, the available means of treatment in relation to the constitution of the mentally ill population and the recognised nature of mental illness.

Such views serve to illustrate that mental health policy formulation and implementation is not about rule following or outcome effectiveness alone, but can be contingent (Dant and Francis, 1998). It involves a range of philosophical and political dialogues and audiences coming together in what is then termed a 'policy', that may be an attempt to reconcile a range of conflicting objectives and perspectives on the issue of society's response to people who are mentally ill (Goodwin, 1997). Two examples will serve to illustrate these points.

Atkinson (1996) argued that the introduction of Supervised Discharge in the UK reflected the political philosophy of the 'New Right' with its emphasis on individual accountability for one's actions and choices. More recently Moon (2000), examining the widely held view that community care in the UK is a failed policy (Department of Health, 1998), argues that the public have lost faith in professional expertise and believe that dangerous risk, associated with placing the mentally ill in the community, needs more effective management. However, the professional orthodoxy that institutional care is deleterious to well being (referred to as iatrogenesis) and that the views of the public are based on 'moral panic' rather than a real danger (Hollway, 1996) must also be encompassed within policy.

Reconciling these conflicting perspectives has led to a re-emergence in mental health policy of the notion of 'confinement' and what Moon (2000) calls "a selectively-applied respectability" (p248) in which particular groups of the mentally ill – severe personality disordered people who are deemed to pose a risk to society and mentally ill people who are treatment non-compliant - may be confined in secure facilities rather than a return to a policy of incarceration for all chronically mentally ill people. In this way conflicting perspectives and agendas are reconciled

4.3 The need for multiple levels of analysis of mental health policy

Pilgrim and Rogers (1999a), drawing on work by Mohan (1996) and reflecting a growing trend to engage in comparative analysis (Goodwin, 1997a; Mechanic, 1995; Light, 1997) argue for what they term an 'open-textured' analytical framework when looking at mental health policy. They argue that mental health policy, or what they prefer to call "the politics of mental health" can be so wide and complex as to affect a sense of paralysis when attempting analysis. In line with arguments that policy examination requires a multi-level analysis (Ostrom, 1999) they argue for a three level framework in which policies are first considered from a macro perspective, then at meso level in which cultural trends and legacies are considered and finally at a micro level, in which the activities of local groups and individuals are examined.

Pilgrim and Rogers (1999a) provide a useful starting point in terms of establishing the idea of levels of relational analysis of policy evolution and/or implementation over time, especially with reference to specific policy developments or movements. However, it has a linear construct to it that may make it more difficult to apply to such questions as the relationship of individual processes to policy *formulation* in an iterative sense, that is the inter relationships between policy formulators and policy implementers. In this context therefore: "the approach of mental health providers in a given era cannot be understood apart from an appreciation of the types of problems they immediately faced" (Rochefort, 1988:148). It is this sense of immediacy, of the speed with which a policy can change or be altered in a welfare area that is often encompassed by controversy that the Pilgrim and Rogers (1999) approach may not adequately capture. In this regard the analytical framework on policy formulation outlined by Callahan (1994) may provide a useful adjunct.

4.3(a) Callahan's three approaches to the analysis of policy formulation

Callahan (1994), writing about mental health policy in the USA, identified three approaches to mental health policy formulation. The first he characterised as 'informal'' in which one priority is emphasised over another because of, for example, political pressure or to correct a perceived wrong. The essential feature of this approach is that it is reactive or symbolic in relation to transitory pressures. Such responses to transitory

pressures can skew policy planning and development. The circumstances leading to the establishment of supervision registers in April 1994 and the policy emphasis on those deemed 'vulnerable' and 'at risk' illustrate this,[13] setting the tone of the debate about mental health policy ever since (Moon, 2000; Carpenter, 2000).

The second approach is a formal and structured non-technical process that attempts to systemise and order priorities into coherent units and groupings. Thus community care policy has been summarised as sensitive and flexible, providing choice, minimal intervention and prioritising those with the most complex difficulties (Tudor, 1996). Policy in this context is based on dialectic between professional values and attitudes of those charged with managing and implementing policy on the one hand, and the results of political and policy negotiation on the other.

The development of CPA is, to some extent, an example of this formal and structured process. The approach was first articulated in a Social Services Committee report (1985), followed by government policy circulars (Department of Health, 1990a and b), and encapsulated in the guidance that accompanied the 1990 NHS and Community Care Act (Hudson, 1993). Initially it was envisaged as applying to anyone who had been accepted by specialist psychiatric services. Such wide application had implications for resources and without extra funding the policy appeared impractical. It was this recognition, combined with evidence that the needs of patients with schizophrenia were not being met compared with other client groups (Hudson, 1993), and critical reports (Ritchie, 1994; Blom-Cooper *et al.*, 1995), that led to a policy emphasis on a tiered system of prioritising. Thus the full CPA was officially seen as applying only to those with the most severe problems (NHS Training Executive, 1995; Department of Health, 1996).

The final approach involves a deliberate effort to incorporate a form of numerical equation into the process of ordering conditions for prioritisation. The last of these three is often seen as the most rational yet, as critics of the quality adjusted life year (QALY) demonstrate, ranked ordering based on such economic calculations may not be rational

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[13] See Chapter 2, Section 2.5

and value free (Harris, 1988). Indeed most health economists would acknowledge that such an approach should not solely determine priorities and resource distribution (Knapp and Beecham, 1995).

However, the influence of economic evaluation and input into policy has grown. For example the use of standardised measurements of health and social functioning became a prominent input into policy formulation from the mid 1990s despite their often untested nature and questionable reliability and validity (Carr-Hill and Jenkins-Clarke, 1995; Allan and McGonagle, 1997). This translated at the clinical level with the development by the Royal College of Psychiatrists of the Health of the Nation Outcome Scales, known as 'HoNOS', the purpose of which was to monitor achievement of Health of the Nation targets (Wing *et al.*, 1995); in particular improvement in the health and social functioning of mentally ill people. HoNOS was specifically designed to be used in the clinical area to assess the nature of patients' problems over time, monitor progress and behaviour change, assess the need for specific interventions and evaluate treatment effectiveness. Data thus acquired could be aggregated and used to measure achievement and set local and national targets (Allan and McGonagle, 1997).

Callahan's (1994) approach to mental health policy analysis thus has a number of advantages. It emphasises that policy may be the product of negotiation and serendipity. It indicates that policy, though often represented publicly as a rational approach to mental health issues, is in fact more complex and likely to be the product of compromises, political influence and power, available resources and public reactions. Last of all it highlights how policy can be rationalised through the use of hard data.

4.3(b) The inter-relationship between practitioners and policy makers

Callahan's (1994) focus is clearly at the meso and macro levels of policy making. Yet as the example of data collection for HoNOS illustrates, the involvement of what might be termed "coal face" clinicians, that is those professionals who have face to face contact with clients/ patients is also significant; since the formal decision makers are reliant on the effectiveness of clinicians in implementing HoNOS and in the data they choose to record.

Mechanic (1997) highlighted this issue in relation to levels of allocative decision-making in health care. Mechanic (1997) sees such decision-making as existing at three levels – at systems, or government level, at intermediate levels, which are local management structures and a third at 'clinical' level. Whilst Mechanic (1997) sees each level as having a primary input into particular types of allocative decisions, he argues that the three levels of decision-making are often inter-related and, by implication, therefore the choices made at each level impact upon and influence future allocative choices between levels. This notion of inter-relationships between the macro level with activity at the micro level is also emphasised by Rochefort (1993), in a mental health context, who states:

> "At least two quite different scenarios of 'top-down' versus 'bottom-up' change are possible. Mental health analysts must explore how each process occurs…".
>
> (Rochefort, 1993:116).

Thus we can see that such arguments identify the inter-relationship between practitioners and policy makers and the reliance of the latter on the former in interpreting policy and their contribution to establishing the degree policy is perceived to be a success. Recent developments within health care in the western world have emphasised the importance of the relationship between resource policy and the practice of clinicians, which is now a significant issue in mental health in the NHS (Mechanic, 1996). As was indicated in Chapter 2[14] the issue of resources was a significant factor in relation to ambiguities around SMI and the tiered CPA. Therefore, a consideration of the relationship between resources, policy goals and practitioners appears an important element to consider in the development of an effective analysis of mental health policy implementation.

4.4 The issue of controlling resource use in policy implementation

We have seen that the analytical approach advocated by a number of writers on mental health policy rests on a notion of different levels of formulation and implementation. This can be seen as mirroring the levels of analysis that exist within the general

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[14] See Chapter 2, Sections 2.2 and 2.3

literature on decision making, that is organisational, group and individual (Cropper and Forte, 1997). As Callahan (1994) in particular demonstrates, the decision processes cannot be divorced from the organisational and political contexts in which they take place, if they are to be fully understood. Central to public policy in the UK over the past 20 years are considerations about the allocation and management of resources and their relationship to the implementation of policy (Savage and Robins 1990; Kane, 2002).

One of the striking features about the development of health policy in the UK in recent times is the progressive determination of central Government to gain greater control over the processes of allocative decision making at all levels of policy implementation within the NHS as a means of containing costs (See for example Department of Health, 1997; 1998b; 1999). Beecham *et al.*, (1996) articulates this within a mental health context when they declare questions of psychiatric treatment cost have an impact on the development and direction of mental health policy.

The emphasis on local and more particularly clinical accountability for resource use is not confined to the UK, but is part of a broader trend within the English speaking world (Mechanic, 1986; Field and Lohr, 1990). It results from a view that clinicians rarely if ever take into account the resource implications of their decisions and thereby are an impediment to the development of a rational and efficient health policy. Normand (1991) amongst others (see Knapp, 1999) characterised these issues in the NHS as a battle traditionally fought over the growth of acute services between politicians and managers on the one side and "shroud waving" clinicians on the other. The changes wrought by the NHS and Community Care Act (1990) were all intended by central Government to encourage NHS personnel at national and local level to be accountable for their expenditure decisions and thereby use resources more efficiently and sparingly (Klein *et al.*, 1996; Scott and West, 2001).

This more resource conscious perspective reflects a utilitarian analysis of opportunity costs, which places greater importance on the benefits foregone as a consequence of a decision rather than the level of individual need. Thus Knapp (1995) states that mental health clinicians need to be aware of opportunity costs to avoid running into difficulties.

This school of thought argues that there is a moral duty to include an economic assessment of choices, because economics provides a rational and objective analysis that is superior to individual decision-making, which is seen as subjective, prejudicial and inconsistent. Indeed, some economists (for example, Mooney, 1992) link morality to rationality and resource accountability by arguing that inefficiencies in micro decision-making pose a serious problem to the rational deployment and use of resources through their cumulative effect. This leads to inequity between patients in terms of distribution of resources.

Basing their argument on Rawlsian principles, health economists argue that making such decision and practice processes previously implicit, explicit is good in its own right (Buxton, 1993). Knapp (1995) believes that economic information through audit and efficiency scrutiny enhances accountability. Williams (1988) argues explicitness will change practice, maximising utility in the face of scarcity and lead to a fairer practice environment (see also Loughlin, 1996).

Within mental health, starting in the early 1990s calls for psychiatric services not to treat what were called the *worried well*, came from a view that limited resources need to be concentrated on the severely mentally ill (Andrews and Teeson, 1994; Gournay, 1996). One can see how such views were reflected in practice when looking at policy guidance from the NHS Executive on the provision of long term care for the elderly (NHS Executive, 1994c). This proposed to place responsibility for who should receive such care on clinicians, who would be expected to take into account the resource implications of their decisions for other patients (Wells, 1995).

The use and collection of information through a greater emphasis on audit, review and defined protocols (Day *et al.*, 1998) is also a manifestation of this shift to an "economic" and resource perspective. More recent policy guidance appears to articulate an explicit 'gatekeeping' role for CMHTs with regards patient access to resources (Department of Health 2000; 2001).

Resource allocation depends on assessment of need to be conducted by clinicians at the micro and meso-level to determine who has rights of access (Carr-Hill 1991). The continuing theme of UK health policy appears to be to draw clinicians at all levels into issues of finance and planning that traditionally they did not see as part of their remit and thereby change their resource committing behaviour (Drummond *et al.*, 1996). Such policy changes can be seen to provide the catalyst through which the influence of economics is translated from the province of macro policy making down to meso and micro level decision-making and implementation.

It is an axiom of economic analysis that in order to understand the economic actions of actors one has to understand how they think about the future (McCloskey, 1986). An implication of this is that if one can persuade actors about the course of the future they will act in ways that one wants or expects. Buxton (1993) argues that in the past clinicians rejected the projective economic view of utility benefit, preferring to emphasise the primacy of the individual to receive treatment regardless of the cost and that the purpose of the 1990 NHS and Community Care Act was to alter this perspective. Thus, McCloskey (1986) describes the economist acting as a *rhetor* - that is a persuader of men to believe what they ***ought*** to believe. To achieve this a persuasive discourse of economics has to be taken up by clinicians as part of the way they relate to the NHS, each other, their patients and the wider community (Buxton, 1993).

Mulkay *et al.*, (1986) suggests that clinicians have internalised these economic arguments within their heuristic framework. Hogan, (1992) sees an emphasis on words such as 'audit', 'needs assessment' and 'information' as indicative of an economic imperative that has become internalised amongst many within health care in the UK.

The collation, supply and discussion of information about the age profiles of the patient population, use of *per capita* resources in relation to needs and so on is particularly important in both defining and reinforcing such internalisation. For example, when such information was not available the conceptions of health problems were not seen within an economic framework; indeed economics were not seen as relevant (Shapiro, 1995). It may be argued that the collection of such information by economists is specifically for

the purpose of demonstrating the aptness and relevance of their analysis to clinicians. O'Kelly (1989) notes that the purpose of establishing budgetary limits in health care is to reconceptualise a restraint as an aim. Rosenbaum (1993) writing on depression demonstrates the degree to which such arguments can be internalised within the clinician's frame of reference:

> "All patients are now inextricably linked one with the other. We cannot give to one without taking from the other "cost-effectiveness" then distinct from cost containment. The latter is to manage money, whilst the former is managed care through rational allocation of resources".
>
> (Rosenbaum, 1993:142)

Economists maintain such considerations lead clinicians to choose the most efficient options in terms of cost and outcome, as well as enhancing accountability for their choices (Sheldon and Maynard, 1993). However, it may be argued that whilst it enhances the accountability of clinicians to managers and policy makers, it is less clear that it enhances clinical accountability to patients. Indeed, one may argue that as economic concepts and precepts are internalised by practitioners and integrated into everyday practice they may exercise a more subtle influence on professionals' decision-making, which goes undebated with a wider audience or indeed with the individual user. A study on the prescription of Respiridone and Clozapine found that a number of consultant psychiatrists did not prescribe it for their patients on the grounds of expense or an assumption that its prescription would not be approved by management (Hogman, 1996).

Shapiro (1998) maintains that a result of the rise of economic discourse is that the discussion of health care in the UK is dominated by a reductionist view in which policy makers and clinicians alike ignore that which is not measurable. In particular he cites the concept of evidence-based medicine as marginalising more traditional notions of professional caring. Shapiro (1998) indicates that professionals, in terms of what is valued, increasingly emphasise those areas of practice that lend themselves to economic measurement and analysis. Thus, Rosenbaum (1993) states: "... the mission of therapeutics becomes integrated with the reality of economic constraints in the concept of 'cost-effectiveness'" (Rosenbaum, 1993:141).

Light (1998) argues that clinical medicine ultimately does not lend itself well to economically derived solutions because it is emergent, contingent on what happens, highly variable and suffused with uncertainty (Light, 1998:8). Health care operates in a largely politicised and emotional climate. It is highly dependent on individual decision making in which rational concepts and supporting data can be deployed in an irrational context. As Sheps and Birnbaum, (1993) have pointed out the economic paradigm assumes that a rational choice exists. There is an assumption that acceptable answers can be found. However, clinical behaviour is often non-rational (Loughlin, 1996) because choices are often constrained by other 'realities' at the macro and meso level, whilst at the micro level one is dealing with the emotion engendered by contact with illness face to face.

Clinicians have a powerful belief and value system based on the centrality of their relationship with their patient, their duty to do all in their power to promote the welfare of that patient and the value of human life. In this traditional view all other considerations are secondary (Nutting and Green, 1994; Seedhouse, 1991). According to Rokeach (1973) such a system informs modes of conduct and determines an individual's views as to what are preferable end states. However, postmodernists, such as Fisher (1998), argue that such values are not fixed but can change over time through discussion and debate.

Utilising this perspective therefore, the discourse, between health economists and the medical professions (and to a lesser extent the public), may very well change their value system to a more "economic" one - which in turn will affect the way they conceptualise problems within health care and their responses to them (Office of Health Economics, 1986). Adaptation to an economic framework may mean that the clinician either defers to such criteria or attempts to "manage" the system by manipulating it.

The belief that clinicians would become *more* rational in their clinical behaviour by incorporating resource considerations within their decision-making framework is therefore open to question. For example, it is well known in the United States that doctors frequently attempt to manipulate patient diagnosis so that patients fit into pre-

determined criteria as a means of manipulating medical insurance coverage (Hunter, 1991). This type of manipulation of criteria on the part of clinicians is known as "gaming" (Elias, 1987; Dopson, 1997). Some evidence of it in the UK can be elicited during the 1990s in the way in which the health and social services disputed boundaries of responsibility, for example, responsibility for elderly care (Social Services Inspectorate, 1995).

4.5 Concluding comments - examining the nature of the relationship between actors, practice, and resources in the analysis of implementation

It can be argued that the arguments health economists propounded for placing '*Economic Man*' within clinical decision-making and its reflection in the development of national policy, imported an economic ideology into the NHS clinical and organisational discourse, which was achieved by relocating power away from clinicians to managers and policy makers. This was legitimated through appeals to rationalism, equity and rationalisation. The medical professions might well be susceptible to such concepts because of their positivist clinical education (Banton *et al.*, 1985; Goodwin, 1997). Yet the degree of influence of 'economic' ideology on mental health practitioners and their practice is not well understood.

It appears therefore, from this review that if analysis is to be effective in understanding the implementation of policy within mental health care it must incorporate within its framework a consideration of whether those charged with implementing policy at local level are influenced by such considerations of resources. Fisher (1998) and Lipsky (1980) provide analytical perspectives that examine the relationship of individual actors to wider policy within a resource context.

CHAPTER FIVE

Policy, Implementation And 'Actors' -

Developing A Conceptual Framework And Study Questions

5.0 Introduction

This Chapter builds on the theoretical and conceptual issues identified in Chapter 4 through a critical examination of the work of Fisher (1998) and Lipsky (1980). This is done with regard the development of a conceptual framework of the inter-relationship of individual actors to wider policy contexts and the questions this raised for investigation.

In Section 5.1, Fisher's (1998) work regarding the heuristics of individual decision-making within resource constraints as it relates to local policy implementation is considered. Section 5.2 discusses Michael Lipsky's (1980) theory of 'street-level bureaucracy', identifying its strengths and weaknesses that need particular refinement and/ or supplementation within the context of examining the work of community mental health workers in the NHS.

In Section 5.3, the framework that resulted from a consideration of the theoretical and analytical issues outlined in this Chapter and Chapter 4 is presented. This is followed in Section 5.4 by a discussion of the process involved in the mergence of the questions highlighted in Chapters 2 and 3 with this conceptual framework. In particular the value of the conceptual framework as a guide to ordering the research questions is emphasised. Finally, Section 5.5 concludes the Chapter by highlighting that once the aims and questions of the study were integrated with the conceptual framework the next phase of this project was to identify an appropriate research approach through which to examine the issues.

5.1 The heuristics of decision-making within resource constraints

Fisher (1998) examines the factors that influence public service managers when making decisions about resource allocation within the context of the New Public Management (Strong and Robinson, 1990; Wiggins, 1997). He argues that managers of public services have a high sense of public duty, but within a context of resource constraints are required by central Government and their own operating environment to determine priorities. To deal with the consequent personal and political complexities with which they are faced they develop heuristics, which he defines as 'mental rules of thumb', that they use at a conscious and unconscious level in their decision-making to determine resource priorities. The application of these rules to their decisions about priorities act as a means of mediating professional and personal stress in relation to their work. He emphasises that such rules are not refined tools of analysis, but rather reflect a person's *weltanschauung,* that is a set of perspectives and values which are used to determine which competing pressures will receive attention.

Fisher (1998) identifies six forms of heuristics that managers within public services apply to dilemmas in the deployment of resources (Box 5.1). He states that the choice of which of the six may be employed depends on particular circumstances or contexts at any one time. Their use is thus not constant but will reflect prevailing political and social attitudes and policies. Fisher (1998) emphasises that the formative factor in determining which heuristic will be employed is not that which produces the optimal outcome, but the one that is most likely to lead to the most acceptable outcome to the various audiences that will be affected or have a stake in the decision. Therefore, Fisher (1998) indicates that factors other than following policy and rational calculation enter into the individual's decision-making processes about resource distribution.

An initial examination of Fisher's (1998) heuristics indicates that they can be divided between those that focus on group outcomes and influences ('fairness', 'utility', and 'ecology') and those that focus on individual issues ('deservingness', 'individual need' and 'personal gain'). In this they reflect the perspective of those that would place more emphasis on economic considerations in decision-making in health care versus the

traditional perspective of the personal commitment of the practitioner to the individual patient and their professional self-interest (Knapp, 1999).

Deservingness	*Dividing resources between groups and individuals perceived as deserving or undeserving. Those judged as responsible for their predicament or demanding/ uncooperative labelled undeserving.*
Individual Need	*A focus on individual need rather than a service. Professional judgements are used to decide which need should be given priority.*
Fairness	*Equalising probability of receipt of service for all. It focuses on standardisation and equal access.*
Utility	*Focused on maximisation of efficiency and effectiveness in relation to the common good as opposed to individual need.*
Ecology	*Allocates resources according to the most significant or powerful stakeholders rather than professional or objective considerations.*
Personal Gain	*Resources allocated to create personal gains for staff involved – job satisfaction, power; achievement of a personal objective.*

Box 5.1
Heuristics of decision-making
(Based on Fisher, 1998)

Fisher (1998) does not classify his heuristics this way, but rather delineates their shared characteristics within the context of policy and social processes that developed during the 1980s and 1990s. In particular he argues that the introduction of a policy of resource consciousness and a market philosophy in the public services led to a greater emphasis on homogeneity in which there is a stress on packages of care (Mechanic, *et al.*, 1995; Jones, 1998) and standardisation of approach rather than trust in professional judgement (Mechanic, 1998). As a result individual need and fairness has diminished in terms of calculation.

Fisher (1998) also argues that the heuristic of 'deservingness' has become more prominent arising from a social and political consensus of self-responsibility and discouragement of 'dependency' in terms of statutory welfare. This is coupled with a greater emphasis on personal gain through the introduction of market philosophies within the public services. Thus the culture of public service disinterest has been

replaced by a culture in which individual self-interest is accepted as a legitimate motivator of action.

Each form of heuristic can be seen to have operated within community mental health. For example, it is well documented that health care practitioners are less well disposed towards the 'difficult' patient (Ellis, 1993). A study by Repper and Perkins (1995) of the common characteristics of rejected client referrals to community mental health services in one health authority found that such rejected clients were often identified by practitioners as 'difficult', meaning aggressive or violent, or unwilling to accept that they needed care input. It could therefore be argued that we can see in this case the 'deservingness' heuristic in operation. In a more recent study of one CMHT's operationalisation of criteria relating to severe mental illness (King, 2001) it was found that the team used the category as a 'rhetorical device' to demonstrate to management that it was meeting Trust targets. In addition it acted as a means of confining the team's workload. It appears in this example the team's determination of which patients fell into the category was governed by both 'ecological' and 'personal gain' heuristics.

Fisher (1998) provides a framework to understand the contextual values that inform individual and group allocative decisions. His emphasis on the inter-play of personal benefit and the acceptability of decisions to audiences is particularly significant in terms of understanding the actions and choices of individuals confronted with the dilemmas arising from managing resources within a public service.

However, Fisher's (1998) proposed heuristics, like that of economists, assume that a choice between two or more competing variables is available to the individual or group. Levi (1990) points out that individuals can find themselves confronting conditions of uncertainty in which conflicts of choice are not resolvable through the use of appeals to decision-making schemata or a balance of different values. He talks about decisions determined by 'admissibility', that is individuals often making decisions without resolving conflicts. In such cases it may be argued individuals will look to develop strategies and approaches for surviving resultant anxiety rather than attempt to choose

between discernable options and outcomes. In this regard the work of Michael Lipsky (1980) on street-level bureaucracy has some relevance.

5.2 Street-level Bureaucracy –A positive critique

Michael Lipsky's work on street-level bureaucracy (Lipsky, 1980) is an attempt to explain why it can often appear that welfare service organisations behave in ways that run counter to their publicly stated regulatory framework and policy priorities. It draws from and is located within the literature on bureaucracy, organisational studies and official/client relations (March and Simon, 1977; Goodsell, 1981; Adams, 1983). It has been argued that the perspective can be seen as a reaction to the Weberian conception of bureaucracy as a tool of neutral rational and predictive implementation and outcome (Johansson, 1992). Though a viewpoint often cited within texts dealing with welfare and public policy (See for example Ham and Hill, 1992), the general impression from the literature is that Lipsky's (1980) perspective is rarely used to study the work of front-line workers in mental health care (Wells, 1997).

Studies have used the theory to examine the work of the police in Texas (Hill and Clawson, 1988); specific individuals working in a number of welfare agencies (Protass, 1979) and the relationship between national policy and education (Wetherley, 1979). Within mental health the perspective has been used to discuss the implications of policy changes in the NHS (Wells, 1997) and the attitudes of members of five county boards of mental health in Nebraska (Wunsch, *et al.*, 1981).

Lipsky's (1980) perspective has been most used outside of the USA in Scandinavia where studies have been conducted on the administration of unemployment schemes and social work practice (Johansson, 1992; Cedersund, 1992; Myking, 1999). Nevertheless, whilst it is not widely used elsewhere to underpin empirical analysis, the concept of street-level bureaucracy does encompass within its framework many of the analytical considerations highlighted in this Chapter so far.

5.2(a) The focus of Street-level Bureaucracy

Lipsky (1980) examines the relationship between organisational processes as they affect policy within a context of implementation, change and uncertainty. He highlights the influence on policy implementation of workers in the "personal" public services at "street level" (e.g. policemen, social workers, doctors and nurses). He defines these workers as "bureaucrats" as they work in organisations that are arranged along bureaucratic lines in which social conduct is organised as a means of transforming problems "into routine duties of experts and to effect the co-ordination of specialised tasks" (Blau, 1963:251). These "bureaucrats" relate to a hierarchical structure, but they closely locate their role within a context of autonomous decision-making, unhindered by pressure from both managers and clients. They often relate to a practice ethos that emphasises being of service to their client group and maximising the well being of individuals (Lewis and Glennerster, 1996).

The nature of their work involves many face-to-face encounters with clients and colleagues that are unobservable by management. The organisation relies on their discretion to make choices about the deployment of often scarce resources in a time-limited context that can be unpredictable and uncertain, applying the rules and regulations of the organisation to 'process' individual cases. In effect, Government and organisations rely on these officials to operationalise policy on the ground. Therefore managers try to ensure the decisions that they make reflect policy, particularly with regard to the use of resources. However, the street-level bureaucrat attempts to avoid control, because autonomy and discretion is seen as a mark of their self-regard and competence as professionals (Cherniss, 1995); allows them to adapt to the complexity of their work environment and enables them to exercise flexibility in their fact-to-face encounters (Lipsky, 1980:15).

Due to their pivotal "boundary spanning" role at street level Lipsky (1980) argues, there is an inherent tension between the worker's professional ideals and the managerial/ policy agenda. As a result street-level bureaucrats may experience alienation in their work since they have no control over outcome or client circumstances nor feel able to influence management and organisational policy. Lipsky (1980) argues that

consequently they develop routines, subjective perceptions and behaviours that can serve to subvert or alter policy. Through studying these work practices and perceptions one can better understand the policy process, which they influence and transform.

5.2(b) Issues in defining the street-level bureaucrat with reference to CMHTs

Lipsky (1980) counts all workers who work in human welfare agencies in a 'people processing' capacity (Protass, 1979) as 'street-level bureaucrats'. That is public employees whose work involves a reconstruction of individuals' identities into 'service users', 'clients', 'suspects' or 'patients'. However, Lipsky (1980) characterises all street-level bureaucrats as 'the same' in nature and activity and thereby fails to take account of differing perspectives within this group (Moore, 1987). For example, street-level bureaucrats who are not required to hold a particular qualification to practise, such as those who work in a housing allocation department, from "professional" and "semi-professional" occupations, such as psychiatry or mental health nursing. These latter groups may face very different environmental and socialised constraints due to expectations arising from history, public stereotyping and the statutory and professional frameworks that empower them to act in their roles and frame their perspectives; what Zerubavel, (1999) refers to as 'thought communities'. These may enable some more than others to resist policy pressures than Lipsky (1980) sometimes allows for and places demands upon them to behave towards clients and colleagues in ways that do not always arise out of organisational and policy conditions.

Such groups have been described as "bureau-professionals" to differentiate them from other 'street-level bureaucrats' (May and Buck, 1998). Bureau professionals have many attributes of professionalism, for example, an ethic of service to individuals, specialised knowledge, exclusive rights to practise in their area of expertise, which incorporates a socialisation process and the existence of a code of professional conduct. However, the legitimacy to exercise these features of discretionary professionalism within a state bureaucratic system, such as that to be found within the mental health services, is highly dependent upon the sanction of Government (Tuohy, 1999).

The configurations of CMHTs[15] consist of many different professionals, differently qualified and with different degrees of social and professional standing (Onyett *et al.*, 1997). They sometimes answer to different management structures (Wilkinson, 1995), for example psychiatric nurses, consultant psychiatrists and social workers, (Oroviogoicoechea, 1996). In this context therefore they are likely to have different professional philosophies, agendas and values with regard the importance of autonomy and discretion in their practice. For example, many professionals working within mental health teams subscribe to a 'democratic model' of working and to an ethos of teamwork (see Onyett *et al.*, 1997). However some professionals may be more committed to these ways of working than others and therefore there is a potential for inter-professional tension within the teams.

A further issue in this context is the degree of differentiation between managers and street-level bureaucrats. Lipsky (1980) characterises the relationship between the two as a clash between the practice values of the street-level bureaucrat and the needs of managers to control resource-committing behaviour. Consequently, he sees the relationship as inherently antagonistic. However, this may not be the case in community mental health in the UK, since many managers within the NHS are drawn from the clinical professions, particularly nursing (Wilkinson, 1995). Managers may therefore experience tensions and conflicts themselves in relation to policy and their own professional constructs and values not dissimilar to those whom they manage. Furthermore, the roles of some members of the CMHT, who would be counted as street-level bureaucrats by Lipsky (1980), may involve a managerial component in relation to other members of the team, for example the Consultant Psychiatrist.

5.2(c) Peer support

Lipsky (1980) highlights the importance for the ''street level bureaucrat'' of maintaining the support of peers in a climate of uncertainty, stress and tension between themselves and management. Blau (1963) and Prottass (1978), for example, demonstrate how front line workers disregard certain rules to enable them to relate more effectively to colleagues. Group cohesion and support is valued for the sense of security

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[15] See Chapter 3, Section 3.1

it provides in a stressful work environment, assisting the individual in the protection of ego integrity. Members of the group value these inter-personal relationships, which in turn have a normative effect on the group's ethos and practice (Ostrom, 1999).

Applying this perspective to the CMHT one can argue that it provides a social reflexivity, focused on the promotion of team members' well-being through the creation of a supportive and secure social climate in which inter-personal and professional difficulties with users, and indeed other external groups to the team such as management, can be contained and addressed (Rogers and Pilgrim, 1996). This and the emphasis on team working within CMHTs (Øvretveit, 1995) means that teams may develop an identity and practice paradigm that needs to be considered outside of the individual member (Opie, 1997). Since the CMHT and the street-level bureaucrat are mutually constitutive elements in each other's world one needs to look at the team's construction of social meaning and identity and the degree to which this interacts with the construction placed on the operational world of the street-level bureaucrat independently of organisational constructions. This issue of team construction of identity and social meaning needs further analysis if relationships to policy implementation and policymaking are to be adequately understood.

Lipsky (1980) argues teams are important in helping to achieve a sense of competence through feedback, collegial advice and socialising the street-level bureaucrat through observation of co-workers' accommodation of conflicting demands (Dressel and Lipsky, 1989). There is an assumption within Lipsky's (1980) position that teams are seen by the professional worker as inherently supportive structures, hence the determination of the street-level bureaucrat to adopt normative team practices as a means of maintaining team support. However, Cherniss (1995) in her study of burnout found that a number of street-level bureaucrats did not find them supportive. We can thus see that Lipsky's conceptualisation of the street-level bureaucrat may need some adjustment when looked at in the context of the CMHT and professional health care workers. However, the central construct remains valid, involving the notion of a worker / workers directly in contact with service users, who conceptualise their activity in terms

of helping those service users whilst reconstructing them to meet a set of normative criteria located in organisational and extra-organisational contexts.

5.2(d) Resources as a cause of professional anxiety

As indicated earlier resources are a central issue in an examination of policy as it relates to changes in the paradigm of practice. Lipsky (1980) sees the relationship of resource limits on professional practice paradigms as a central cause of tension between the street-level bureaucrat and the management of the organisation in which they work since it places overt limits on their autonomy and has been seen as an important component in professional stress and burnout amongst public servants (Cherniss, 1995). This has been found to be the case within hospital based mental health nursing (Firth *et al.*, 1986; Handy, 1991).

However, Lipsky (1980) does not fully consider the degree to which internalising a resource management paradigm can change the values of the street-level bureaucrat and thereby the principles that guide their practice. Thus, the policy issues that cause anxiety may not entirely be resource related. For example, Test (1990) notes that mental health professionals do not like to work outside of their professional models. This can lead to resistance to change in professional working in the community. Such resistance may be seen on the part of managers as obduracy, and can lead to a lack of consultation with front line staff in strategic planning. However, this obduracy may in fact be a pragmatic coping with what are difficult practice environments (May and Buck, 1998).

Ramon (1985) identifies a central cause of anxiety for mental health workers as a tension between their caring and restorative function on the one hand, which they see as their source of legitimation, and their role in social control on the other. This may be seen in concerns about implications for the relationship between clinician and user raised when the Supervision Register and Supervised Discharge were introduced[16] and, more recently, Government proposals on the management of people with severe personality disorder (Department of Health and the Home Office, 1999).

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[16] See Chapter 2

5.2(e) The rôle of routines and rules in managing anxiety

Lipsky (1980) argues that individuals enter public welfare organisations with a commitment to values and rôles that emphasise "service", often enshrined in organisational "mission" statements. However, these public services operate within an environment of limited resources and demand pressures that often encourage the development of conflicting policy priorities. It is this environment that hinders "street-level bureaucrats" from providing their ideal of "service". The reality of the resource constraints on their work rapidly leads to value and role ambiguity in relation to what they are asked to implement by policy makers and managers, that is a form of 'sociological ambivalence' in which there is a conflict between normative expectations (Merton and Barber, 1976) that lead to a sense of professional and personal anxiety.

Dewey (cited in Boydston, 1983), for example, argued, "authoritative rules … are props for a feeling of safety" (p167). Beck (2000) more recently states that within modern society the threshold for the tolerance of 'risk' has decreased, with a particular emphasis in public services to eliminate risk,[17] "Everything falls under an imperative of avoidance" (Beck, 2000:217). Within Lipsky's (1980) context of managing personal anxiety arising from the complexities of uncertainty, demands and tensions between the organisation on the one hand and service users on the other, street-level bureaucrats develop routines and working methods in "processing" their client group so as to cope with their inter and intra-personal dilemmas and stresses. This may be seen as a form of risk management and personal harm reduction on their part, particularly in relation to their relationship with organisational management.

Blau (1963), in a classic text on bureaucracies, noted that ritualism arises when there is a lack of security in important social relationships within organisations, particularly in relation to superiors. This can significantly affect policy implementation at the "coal face". Street-level bureaucrats, it is argued, will adhere to such routines/ ritualism because of the security they provide and consequently are reluctant to change them (Merton, 1957).

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[17] See Chapter 3, Section 3.5

Lipsky (1980) sees routines as a means of coping with street level anxiety. However, they may go beyond the role he ascribes to them at street level, serving also to mediate the anxiety of middle managers and a general 'organisational' anxiety when coping with the vicissitudes of a politicised and changing context external to both the street-level bureaucrat and the organisation (Karen, 1990). Thus NHS managers, anxious to be seen by their superiors to be implementing government policy may focus on process and conformity amongst street level bureaucrats to manage their own anxiety.

Rules and routines develop in an attempt closely to control workforce activity and focus effort on the goals the manager is expected to achieve for the organisation. This is particularly so within the context of a community mental health care organisation, where many of the employees freely interact with non-organisational professional groups and may subscribe to the views of these groups toward policies rather than adopt those promulgated by the organisation. Thus standardising procedures protects the organisation against these attitudes that may not be consistent with operational goals (Aldrich and Herker, 1977).

5.2(f) The role of discretion and expertise in street level bureaucracy

The concept of discretion relates to the degree of flexibility possessed by an individual in decision-making based on claims to possession of a professional expertise (Brodkin, 1988). It is usually embedded within a rule structure in which attempts are made by an organisation to define explicitly the circumstances in which it may be exercised (Lipsky, 1980). The significance of discretion for Lipsky (1980) is that it is the primary means through which street-level bureaucrats alter policy intentions. For example, May and Buck (1998), found that social workers' sphere of discretion allowed the persistence of "old" practices despite the introduction of new regulations regarding process.

Within mental health services clinicians, particularly psychiatrists, occupy a pivotal role in determining policy implementation since through their exclusive power to make a psychiatric diagnosis they can construct the parameters of service use. Their diagnostic expertise gives them the power to enable or deny access to services, thereby determining the level of resource commitment on the part of services and the direction

and content of data collection (Brown, 1987). The autonomy conferred upon psychiatrists or psychologists through exclusive control of diagnostic power serves to reinforce the position of the professional street-level bureaucrat selectively to reinterpret or ignore policy guidance (Hunter, 1991). Indeed, Brodkin (1988) identifies that once an issue falls within the remit of 'expertise' it reduces the legitimacy of the 'non-expert', such as an operational manager, to participate in or challenge decision-making. However, this may not be the case within community mental health services where a number of managers are drawn from the same professional bodies (Wilkinson, 1995).

Expertise also serves to differentiate the power relationships within the CMHT. The legitimacy of status and power between the differing professional groups to be found within a CMHT rests on the medical control of diagnostic power. This enables the consultant psychiatrist to determine the distribution of work amongst the other professionals within the team, thereby transforming him or her from a street-level bureaucrat to one who exercises a formal managerial function. This blurring of boundary, where a practising street-level bureaucrat also acts in a managerial capacity is insufficiently considered within Lipsky's (1980) work.

When looking at the issue of discretion, therefore, one must take into account the degree to which rules permit its exercise, by whom (Leidner and Herker, 1977) and the degree that the rules themselves are obeyed or broken by the street-level bureaucrat. Fox (1974) relates the imposition of top down rules to the degree of trust that exists between superiors and subordinates in organisations in which discretion is exercised. The lower the trust relationship the greater the degree of attempted prescription. However, rules can be imposed from outside the duality of this relationship, for example through a governmental lack of trust both of managers and professionals.

The degree of prescription within an organisation such as a mental health NHS trust, therefore, may not be symptomatic of a lack of faith between professionals and management, but rather a lack of faith on the part of the political establishment which establishes the context in which these groups have to operate. For example Hadley and Clough (1996) argue that there was a breakdown of trust between managers and

managed and between organisations because of the purchaser provider split. Detailed budgets and specifications reduced the area of discretion of frontline workers. Yet, the catalyst for this particular breakdown of trust resulted from the rules imposed by Government on the stakeholders in operating the internal market.

5.2(g) 'Off stage' work, professional needs and rule manipulation

Leidner (1993) points out that all interactive service work consists of both an interactive and non-interactive component, the latter he terms "off stage". This 'off stage' work often consists of form filling and clerical work, which is fairly easy for organisations to both routinise and scrutinise. However, the interactive elements are more difficult to control and examine because, "the distinctions among the product or outcome of the work, the work process and the worker may be blurred or non-existent" (Leidner, 1993:26). May and Buck (1998) note the, "inability of administrative edicts to fully determine the actual performance of work in what are complex, human service organisations." (May and Buck, 1998:72). Morrall (1997a), in a study of the working practices of CMHN's in four CMHTs found that lack of observability gave CMHNs a *de facto* autonomy for which the organisational system did not allow and permitted CMHNs to discharge users from their case load without prior discussion with CMHT colleagues or reference to evaluative criteria or policies.

These factors raise three issues as they relate to community mental health services that need to be considered. The more general issue is that which is recorded in information returns may reflect only a partial 'reality' of practice, though management may often rely on such recording as 'proof' of what is taking place. Blau (1963) demonstrated that front line workers are adept at deliberately altering data to demonstrate improved performance, especially when that data is statistical. Alternatively, others have testified how mental health practitioners can manipulate information and formal criteria through the assessment process (Brown, 1987; Korman *et al.*, 1996). This helps to explain the disparity that can arise between policy intentions, government statements and the reality experienced on the ground.

The second issue is that both management and fellow clinicians may see the behaviour of users as a reflection on the competency of the practitioner/ CMHT. Thereby, the behaviour of users may assume a personal importance to practitioners and teams beyond the clinical issue of their mental health, in which the control of user behaviour becomes a means of allaying personal anxiety rather than as a therapeutic aim. Thus it has been argued clinicians possess interests that they pursue that at times over those of their patients (Williamson, 1993).

Rogers and Pilgrim (1996) argue that "needs" can be seen as a synonym for interests and can be analysed as a dynamic between groups of social actors, "Needs ultimately are defined and explained in terms of states inside individuals, who are always patients or clients and very rarely professionals" (Rogers and Pilgrim, 1996:179). Rogers and Pilgrim (1996) ask whether clinicians express their own needs behind their articulation of the needs of clients. One of the strengths of the concept of street-level bureaucracy is that it encapsulates this very issue of internalised needs on the part of professionals and how it may articulate itself through their actions in relation to services and clients.

One needs to consider which rules and guidelines practitioners choose to follow or ignore in this light. Hill (1997) argues that such decisions are made with a view to a "bounded rationality" in which the decision maker chooses not to maximise their values, but rather to be seen to be satisfactory or good enough. This has a certain synergy with Fisher's (1998) and Levi's (1990) arguments for decisions being determined by perceptions of 'acceptability' and 'admissibility'. Hadley and Clough (1996) argue that one needs to consider the degree of perceived personal threat and consequence when looking at this issue.

Lipsky (1980) considers these perspectives. He argues that organisational rules and routines that reduce anxiety and make environments less stressful will be followed. Thus rules that add to the burden of stress will be ignored or subtly re-interpreted. The opportunity to pursue personal interests in this way may be facilitated by the unobservable nature of much of the work in street level bureaucrats are engaged. For example, in a context of limited resources and face to face encounters with service

users, rules and routines can allow an issue to be depersonalised and provide a legitimisation to say "no" to demands deemed organisationally unacceptable yet are professionally deemed reasonable. In this case therefore they mediate intra-personal value conflict and personal stress. Alternatively, teams may require that assessments be conducted by the team, thus sharing the responsibility for refusal to intervene.

Moore (1987) considers Lipsky too deterministic in this regard, arguing that street-level bureaucrats engage in a decision-making process that may not be an automatic response to the alleviation of anxiety caused by their work structures, but one that involves more 'political' processes in terms of the pursuit of personally emergent goals. He therefore argues that Lipsky (1980) does not fully consider the individualised motivations employed by the street-level bureaucrat when making decisions. He argues that to understand street-level actions one must view street-level decision-making as involving strategies aimed to "assimilate or to balance multifarious competing pressures" (Moore, 1987:82).

5.2(h) Changing policy at street-level

Lipsky's (1980) central contention is that policy is re-interpreted at street-level as a means of managing anxiety through developing standardised responses to client situations. It is this activity that can change/ divert the policy from what was intended by those who formulated it. Bardach's (1977) study of Community Mental Health Centres (CMHCs) noted that stakeholders often engage in strategies to manage their workload by focusing on particular groups of users rather than those prioritised by policy. He also noted the degree to which individuals and agencies in order to protect what they see as their professional 'sphere of influence' engage in activities that obstruct cooperation. As Rochfort (1993) notes such work indicates that policy 'failure' is not the result of random processes, but a consequence of specific conscious actions on the part of individuals and agencies charged with their implementation. Lipsky (1980) provides three specific constructions on how this re-direction of policy is done (Box 5.2).

Process	Motivation	Policy Consequence
Projection of personal responsiveness to individuals' needs	Disguises constraints under which the practitioner has to work and ameliorates dissatisfaction on the part of the user	Deflects responsibility for the outcome of resource decisions from central government to localities and teams
Exercise of discretion as to who shall/shall not receive input and degree	Non-operation/ minimal collaboration with policy the clinician views as non-legitimate	Re-direction of organisational behaviour/ priorities through aggregate of clinicians' decisions
Meeting explicit criteria whilst ignoring those aspects not explicitly stated	Allows mediation of professional/ personal anxiety in meeting objectives	Priorities appear to be met at policy making/ management level, but is significantly distorted at the "felt end" of delivery

Box 5.2
Mechanisms through which street-level bureaucrats impact on policy priorities

The first, 'responsiveness' involves an attempt to project a persona of being responsive to the individual needs of service users in order to cover up the policy and resource constraints under which they work. This is a form of client manipulation to secure compliance in order to enable effective action on the part of the street-level bureaucrat (Lipsky, 1980). This suits both policy makers and managers, as they do not wish to be seen as responsible for the shortages that can result from their decisions (Mechanic, 1995a). For example, Hogman (1996) in a study on the variables that affect the prescription of more expensive psychotropic medication noted that management "subtly discouraged from using them rather than overtly or formally so" (Hogman, 1996:17). Hogman (1996) noted that a minority of psychiatrists as a result admitted that they prescribed cheaper though less effective alternatives.

The 'street level bureaucrat's' exercise of discretion may redirect organisational behaviour and priorities as a result of the aggregate of their decisions or by non-operation with those parts of policy they find objectionable (Henwood, 1995). Managers, according to Lipsky, find this difficult to control as any action on their part is seen as an illegitimate interference in the professional relationship between expert and

client. Furthermore, those managerial means of asserting control such as quality assurance and audit rely, in the case of the personal social services, on the autonomous professional reporting upon themselves. Thus those whose activity the policy is supposed to control can significantly affect managerial feedback as to policy success.

Organisations and managers traditionally attempt to shape and control workers' activities through the operation of incentives (usually financial and or promotional) and penalties as they relate to policy targets (Hudson, 1992). Thus street-level bureaucrats may devote their efforts to meeting explicitly stated objectives of management. However, within a context of limited resources they may do this by ignoring or paying lip-service to those activities which are not explicitly identified as significant but are, nevertheless, important aspects of the service experience they provide. Thus the policy agenda appears to be met at management and policy level but in fact may be significantly distorted at the "felt" end of public experience. The result of street-level bureaucrats focusing on strict policy targets can therefore have unintended consequences for the outcome of policy.

5.2(i) Concluding thoughts on Street-level Bureaucracy

Lipsky (1980) provides a useful framework in which to locate the analysis of policy implementation, emphasising the need to consider implementation at the 'felt' end of policy. However, Lipsky (1980) appears to assume that 'street level bureaucrats' are primarily the conduits of policy. His conception of their influence on policy does not encompass their influence when they are the direct targets of policy with managers as the implementers. Yet as has been indicated in this chapter and Chapter 1, there was and is within UK mental health policy a focus on clinical practitioners and changing their behaviour, particularly in terms of incorporating a resource and 'risk' conscious framework into their clinical calculations.

Lipsky (1980) requires the analyst of policy implementation to consider how the interaction of inter-personal and intra-personal tensions and their management affect policy. In order to do this one must incorporate an assessment of the influence of managerial, group and professional normative values on the individual worker when

operating in an environment of uncertainty. However, Lispky's (1980) theory needs particular refinement in the context of the CMHT, incorporating a consideration of the effect of differences between the professional and operational status of the various professional backgrounds found within the teams and how these differences impact on individual and group perceptions of normative values.

5.3 Constructing a conceptual framework

In Chapters Two and Three it was indicated that mental health policy in the UK during the 1990s was underpinned by values of fiscal rectitude and the containment of risk. In this context therefore a number of factors need to be considered in the investigation of the theoretical issues surrounding the process of policy implementation within community mental health care. These incorporate macro and meso questions pertaining to the nature and intention of community mental health policy within an environment of contingency, and how these reflect and interact with national and local intentions and guidelines that are used to define and regulate the areas of action in which managers and street-level practitioners operate.

A significant area of interest in this regard is the relationship of policy process at local level to the perceptions of policy held by individual actors such as managers and clinicians, and how these individuals negotiate policy based upon these perceptions within their operating groups, such as CMHTs, at the 'street-level'. The degree to which the values underpinning policy are internalised by implementers into their world view at both a conscious and unconscious level is likely to be of significance. Differences between actors in relation to value internalisation may contribute to the complexities of joint action between the various CMHT practitioners, with their concomitant professional affiliations, through a team reflexive process.

Taking these factors into account therefore, it would appear that analysis of the relationship between community mental health policy implementation primarily falls within Guba's (1984) domains of 'Policy-in-Intention' and 'Policy-In-Action'. Consequently, one needs to examine the association between intended outcomes, rules and guidelines on the one hand and expectations, norms, interpretations and activity on

the other. The role and relationships between formal policy makers, managers and street-level implementers needs to be looked at if this association is to be fully appreciated.

One needs to consider influences that interact to shape perceptions and implementation at local level within an overall policy context of uncertainty and the broad dictates which available resources impose. The 'street level' worker's perceptions and their effect on decisions, both at the individual level and within the clinical team, need to be looked at in order to gauge the result of the sum total of these elements and how they serve to reshape and transform the experience of policy. Furthermore, managers as implementers need to be considered when the primary focus of a policy is on changing the behaviour of clinicians rather than the service user.

These relational questions can be represented conceptually as a contradictory environment of policy specification and uncertainty in which individuals not only perceive and operate at an individual level but also interactively, with groups of colleagues, within organisational structures and with policy environments and policy stakeholders (See fig. 5.1). Underpinning this conceptual framework are theories outlined by Callahan (1994) on macro and meso policy formulation, Pressman and Wildavsky (1984) on the nature of *joint action*; Fisher (1998) on the heuristics of decision making in relation to resources and Lipsky (1980) on the motivators underpinning street-level implementation. The value of each is that they recognise the contingent and non-rational elements of policy implementation and highlight the importance of both individual and group cognitions, activities and motivators in the interpretative process of implementation. They can be related through reference to Pilgrim and Rogers (1999a) conception of policy analysis as having a three level relationship and Guba's (1984) view that focus is dependent on chosen policy definition. As such, a combination of these elements can provide an integrated insight into policy at macro, meso and micro levels.

The conceptual framework as formulated (fig.5.1) consists of an outer circle, representing a bounded context of mental health policy that is defined by the

Government, public debate and stakeholders. Within this context are represented three elements that operate at the interface between policy and street level. These elements are both distinct and yet inter-related, and therefore have been visually presented in the form of a Venn diagram.

The two outer elements represent the significant interactive groupings at the street level, Trust management and CMHT, which are expected to operationalise policy. The third element represents the implementing actors within these groups whose interpretations of policy 'feed' into the deliberations of their respective groups, but who also interact with each other as individuals, thereby, it is assumed, influence one another in terms of perceptions and actions.

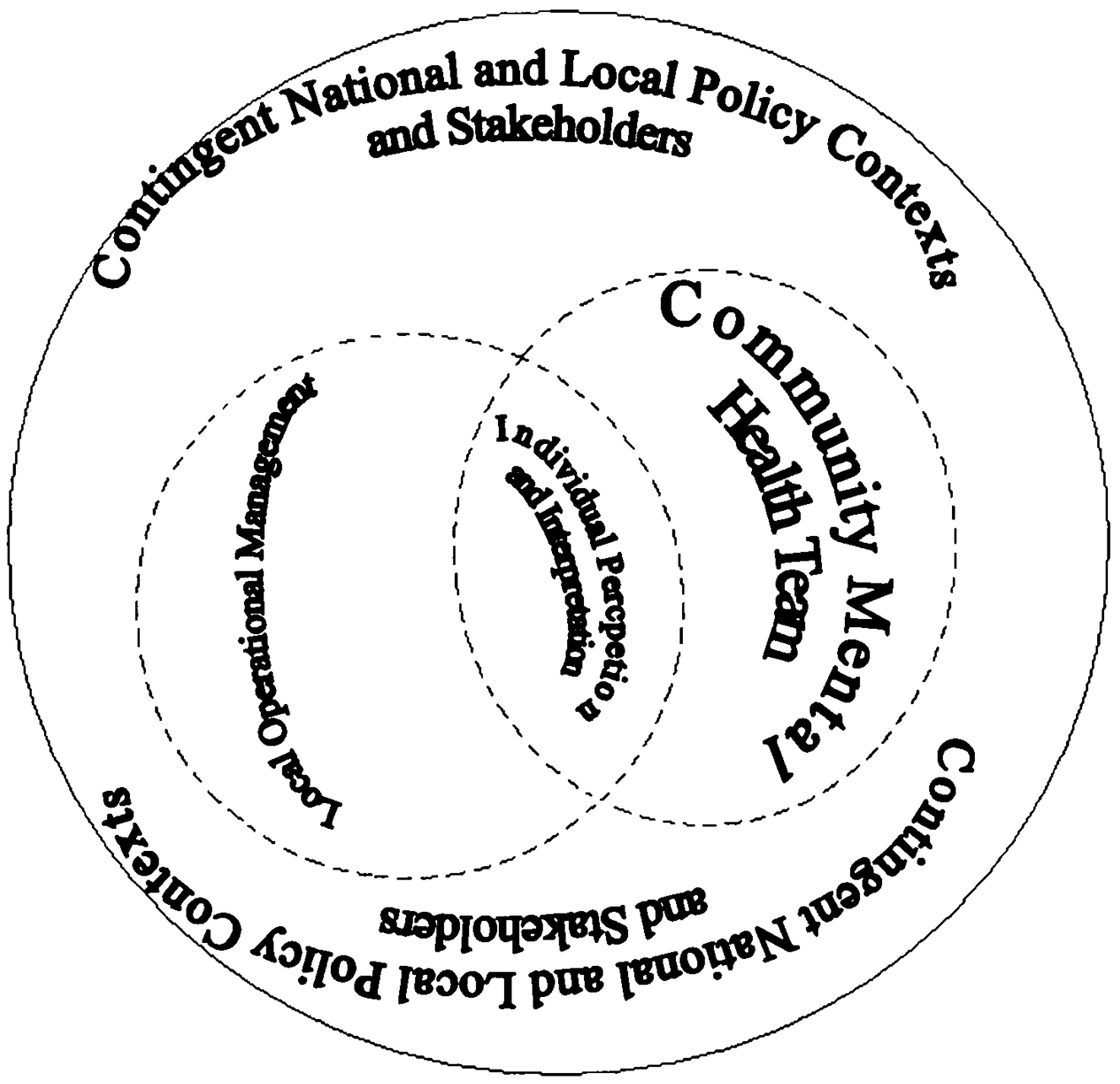

Figure 5.1
Conceptual Framework Guide
The Inter-Relationships Between Individuals And Groups Operating Within A Mental Health Policy Context

It will be noted that the boundary lines around these elements are not solid. This represents the issue of the degree to which these elements create the context of which

they are a part and also because some stakeholders that appear located in the context may also be associated with the core elements, for example, local commissioners of services, or clinicians who are employed within a community mental health service but may also hold organisational and policy advisory positions. Within this conceptual framework therefore, the boundaries between the macro environment and the meso and micro levels of analytical focus may at times be unclear because of the iterative level of formal and informal interaction and relationships between actors, and their influence and shaping of perceptions and actions at all levels.

5.4 Refining the study aim and placing the study questions within the conceptual framework

Majchrzak, (1984) argues that a conceptual framework is an important pre-requisite in policy related research in order to locate the issues/problems for study within a preliminary framework that aids in the research design process. This, Merriam (1998) states, clarifies the set of questions that need to be answered within a study, which is seen as an essential pre-condition for the development of a research design (de Vaus, 2001).

The development of the conceptual framework (fig.5.1) highlighted that this study was concerned with relationships between individual and group paradigms and those of policy, both in a local and national context. Paradigms, as guides for action, are often based upon unquestioned assumptions. This is their strength because they provide an immediate framework through which clinicians can negotiate practice complexities (Schön, 1991). However, this is also their weakness because they often hide the reasons for that action (Lincoln and Guba, 1985).

Thus an important rationale for this study was the examination of these professional/ individual paradigms and assumptions in the context of relationships, the community mental health services and teams within mental health policy that had a temporal, societal and political aspect. Underpinning this view is an assumption, based on my *a priori* knowledge as a mental health nurse, a review of relevant literature and the theoretical issues discussed that the practice and views of personnel within CMHTs may

have a "professional" character that is either at odds with the policy paradigm or might change in response to it. For example, the emphasis on resource consciousness at practice level may be internalised within the practice paradigm of individual clinicians and translated into group policies and routines, both formally and informally.

Study questions:

- Are particular policies emphasised and in what ways at local level?
- To what degree are policy principles internalised and why?
- Are there differentials in perceptions and emphasis about policy between the various professionals within management and the CMHT and why?
- How do professional, situational and personal factors affect policy interpretation and implementation?
- How and why do managers, practitioners and teams negotiate policy tensions and implementation?

Issues of investigation:

Context:

- What are the aims of policy?
- Why are particular policies emphasised?
- How is policy communicated and to whom?
- How is policy compliance monitored?
- Which policies are identified as problematic and why?

Local Operational Management:

- What are identified as priorities?
- Which and why are policies identified as problematic?
- How are priorities communicated to CMHTs?
- How is local compliance monitored and communicated to stakeholders and CMHTs?
- What causes individual managers anxiety with regard policy and why?

CMHTs:

- Of which policies are the CMHT conscious and why?
- What are the priorities for the CMHT and why?
- What does the CMHT communicate to management and why?
- Are there differences of policy perception between the various professionals within the CMHT and why?
- How and why do differences of policy perception affect relationships within the CMHT and its operationalisation of policy?
- How and to what degree does the CMHT influence the individual practitioner?

Individual:

- What are the individual perceptions held of national policy and why?
- Of which polices/guidelines/local requirements are individuals most conscious of/ internalise and why?
- What tensions exist for the individual practitioner between different normative expectations (professional, organisational and personal) and why?
- In what way does an individual's conceptualisation of their role/identity affect their views of policy

Box 5.3
Research questions integrated with the domains of the conceptual framework

Arising from a synthesis of these ideas is a central issue that needs to be looked at within this study. This issue is whether the relationship of perceptions/ attitudes towards mental health policy affects compliance within a context of limited resources and a changing context of policy/ professional points of reference. A concomitant issue is the reason for professionals interpreting policy in particular ways.

Taking account of these issues provided the basis for the formulation of a general aim for this study. The main elements the aim needed to incorporate are relational, and include individual and group interpretations with their affect on perceptions, compliance and a contingent context. It was decided not to emphasise the issue of resources as an overt factor since it might lead to a bias in the collection and interpretation data. Thus the aim for this study consists of two questions, a descriptive 'how' and an explanatory 'why':

'How and why do the relationships and attitudes to policy of individuals, Community Mental Health Teams (CMHTs) and local management influence understanding and implementation'

Having developed the study aim, the specific questions were further refined, through reference to the levels suggested in the conceptual framework (fig.5.1) - the contextual, operational management, CMHT and individual (Box 5.3).

5.5 Conclusion

The questions that needed to be investigated within the conceptual domains (Box 2.6) were not assumed to be definitive in terms of areas of focus, but rather to be a starting point. It was expected that as data collection and preliminary analysis proceeded, further issues would arise (Vaughan, 1992). However, the domain questions served to provide a focus for thought on selecting a research approach and the organisation of data collection and analysis. These issues form the subject of Chapter 6.

PART II

RESEARCH PROCESS

CHAPTER SIX

Selecting A Research Approach –Case Study

6.0 Introduction

This Chapter outlines the reasons for choosing the research approach used within this study – case study method. The decision process that informed the choice of methodological approach and construction of 'the case' is discussed. This discussion is located within the literature because this played a significant part in decision-making.

Section 6.1 outlines the general considerations that informed the selection of the research approach. Particular reference is made to the reflexive elements involved in this process, especially the synergistic relationship between my background as a mental health nurse and the role of the investigator in qualitative research. This discussion is developed in Section 6.2 in which the considerations that led to the adoption of a case study approach are discussed.

Section 6.3 considers issues around the definition of case study as a method of enquiry and the conceptualisation of case study method as used in this study. This section details the wide variance in the literature on what constitutes and defines a case study, and the consequent implications for the degree to which one may generalise from case study to wider issues.

In Section 6.4 discusses the significance of delimiting 'the case'. The difficulties encountered in attempting to do this and how they were dealt with are described. In Section 6.5 discusses the process of identifying the 'object' of study - CMHT s and the organisation in which they operate – in order to examine 'the case'. This is followed in Section 6.6 with some concluding comments on the synthesis of the review of these issues into an understanding of case study method as applied in this study.

To conclude the Chapter, Section 6.7 presents a conceptual model indicating the relationships and degree of integration between *a priori* knowledge. theory, the conceptual framework, and research questions that underpin the notion of 'the case' as used in this study. In summation it is argued that criticisms of case study and whether one can or cannot generalise from it are based on the subjectivity of the inquirer as this relates to bias and the representativeness of the sample. It is further argued that neither criticism is appropriate.

An important point to emphasise in the description and discussion contained within this Chapter is the iterative nature of the research process over time. That is that whilst for the purposes of comprehensibility an order of presentation is constructed, in fact the thoughts and rationales within this research project were part of a developmental process that was somewhat more 'chaotic' than a written description is able to convey. It was not settled at the very outset of the study, but changed somewhat, particularly in the early stages of the project. For example, thoughts on reflexivity (See Section 6.2) and case study developed alongside the data collection and analytical process. Thus, as indicated in Section 6.5, the issue of explicating the temporal boundaries of 'the Case', was something that only became apparent after the data was collected. This needs to be borne in mind when reading this Chapter

6.1 Decision processes in the selection of a research approach

One of the immediate tasks to confront the researcher is the methodological path one needs to go down in order to investigate the issue of interest. In other words should one utilise a qualitative or quantitative strategy or indeed a combination of the two. The literature over the years has vigorously rehearsed the intrinsic merits of each, often by decrying the merits of the other or by proposing an alternative to this dichotomy (See Mason, 1994; Wainwright, 1997 for examples of this debate). In recent times there appears to be a gradual acceptance that each has strengths for its research purpose (Hammersley, 1992) and that indeed the distinctions between the two are more apparent than real (Schofield, 2000). However, it is not my intention to go over what is by now rather old though interesting ground. In this Section the general considerations that informed the adoption of a qualitative case study design within which to frame data

collection and organise analysis are outlined. This section will not consider the nature of qualitative research *per se,* which has been well covered elsewhere (Denzin and Lincoln, 2000), except as it affects this study in particular.

Adopting a 'street level' view in which one looks at the centrality of the individual within the conceptual framework[18] indicated that the research approach needed to be able to facilitate an examination of the agency of individuals, how and why they come to understand and do what they do, their relationship with the structure of groups and systems in which they operate and how and why these levels affect individuals within these structures (Giddens, 1993). This implies that people's experiences are multi-dimensional and interpretative (Layder, 1993; Merriam, 1998). Therefore, the approach would need to capture relationships between attitude and action mediated through factors such as situational issues and contexts, organizational structures, and the relationships between the particular actors involved.

The study would thus be concerned with individual, shared and dissonant understandings/ interpretations and their relationship to contextual issues and processes. These considerations would require personal observation and interpretation in a naturalistic setting (Baszanger and Dodier, 1998). This ruled out a deductive analysis based upon quantitative methods. The study of the influences upon individual and group perceptions and interpretations of policy appeared, therefore, to indicate that in terms of *methodological appropriateness* (Patton, 1990) the approach needed was a non-positivist one.

6.1(a) The issues to arise when choosing a qualitative approach

Choosing a qualitative approach was intellectually challenging. Though Lincoln and Guba (1985) provide an ample critique of positivism and its weaknesses it is nevertheless the dominant conceptualisation amongst researchers socialised within the natural science paradigm that underpins the logical –deductive concept of inquiry successfully promulgated by the 'Vienna School' and the British empiricist tradition so

[18] See Chapter 5, fig.5.1

dominant across academic disciplines and particularly dominant within health care (Sjoberg *et al.*, 1991; Porter, 1987).

It can be a struggle to break free from these conceptions in order to progress thinking (Stake, 2000). This is because compared to the apparent singular certainty of positivism the debate to which one is exposed in exploring qualitative research can be confusing and complicated, not least as a consequence of the plethora of terms used by different authors for apparently the same thing (Johnson *et al.*, 2001) and the varied epistemological and ontological perspectives propounded (Patton, 1990; Schwandt, 2000). In comparison, positivism's reductionist nature and apparent logical certainty provide a guide for action that can also give a sense of personal security for the researcher during the research process. In effect it may assist in reducing anxieties that can arise on the part of the inquirer, such as which procedures to employ to investigate an issue, during the research process (Johnson *et al.*, 2001).

In addition to these factors, at the time ideas for this study were formulated, I worked within an academic department that had a high reputation for the quality of its research and whose most senior researchers (though by no means all) tended to have a positivist ethos. The influence of this environment may be seen on my early thoughts on this research project, which were quite positivist in construction. The early draft of this study, for example, was to look purely at the decision process employed by nurses in mental health when 'rationing' health resources. Data collection and analytical procedures reflective of this ethos, would examine the use of vignettes with practitioners (Wilson and While, 1998) through quantitative decision analysis techniques (Doubilet and McNeil, 1991; Corcoran, 1985). However, after further reading and reflection the singularity of this focus and the accompanying analytical methods was rejected, on the basis that they could miss many important issues, such as temporal, situational and policy contexts, and would not capture interactive and internal processes.

Overcoming a personal anxiety about adopting a qualitative paradigm to investigate the study issues was based on a two-fold realisation. Firstly, there was a recognition that the

issues and context strongly indicated that this was the appropriate route. Secondly, the emphasis in qualitative or *naturalistic* inquiry on the researcher as *instrument* (Lincoln and Guba, 1985) had a natural synergy with my professional background as a mental health nurse. Lincoln and Guba (1985) characterise the attributes of the *researcher as instrument* as responsiveness; adaptability; having a holistic emphasis; focused on knowledge base expansion; and possessing a 'process' immediacy, that facilitates adaptation to context and awareness of the resultant biases.

Within mental health practice there is an emphasis on the nurse as a *therapeutic instrument* (Department of Health, 1994c; Barker, 1997). Thus the *instrumentality* of the practitioner within mental health care was something of which I had experience and with which I felt comfortable. The nature of the work of a mental health nurse is to come to an understanding of the patient's perceptions and experience in order to comprehend what motivates them to action. In other words the mental health nurse, like the qualitative researcher, is engaged in an inductive process in which the development of a relationship with an individual in order to attain an understanding of the 'lived' experience of the patient lies at the core of the 'helping'/ 'research' activity (Merriam, 1998).

Cutcliffe and Goward (2000) argue that the centrality of relationship building within mental health nursing differentiates members of this discipline from their colleagues in other branches of nursing and, therefore, they are more likely to adopt a qualitative approach when engaging in research. Cutcliffe and Goward (2000) also point out that qualitative research by its nature can often be an uncertain and unpredictable undertaking and that this is also reflected in the work of mental health nurses. Thus they argue that the combination of relationship building skills and dealing with uncertainty make mental health nurses particularly appropriate practitioners of qualitative research.

Cutcliffe and Goward's (2000) identification of the attraction for mental health nurses of qualitative research approaches because of the centrality of relationship building in both did, on reflection, play a part in my decision about adopting a qualitative approach. However, their argument that mental health nurses are attracted to a qualitative

approach because, like qualitative researchers, they incorporate uncertainty in their working practice was not reflective of my own concerns about uncertainty. Neither is their argument greatly supported by recent developments in mental health nursing. Over the last ten years there has been a desire for greater security in practice (Bray, 1999) with an increasing professional emphasis on defining and upgrading the discipline's skills base (Butterworth, 1995; Chan and Rudman, 1998), and a policy emphasis on defining the specific responsibilities and duties of mental health nurses (Department of Health, 1994c) as a means of providing *greater* certainty in practice, for example the popularity of psycho-social training schemes and the emphasis on the management of particular diagnostic categories (Brooker and White, 1997; Norman and Howell, 2000) Overall, the professional and policy thrust in recent times has tended towards a desire for conformity and predictability in relation to training and practice to control for and reduce uncertainty rather than embrace it as a defining feature of practice.

These developments appear to be indicative of a profession that is uncomfortable with uncertainty rather than one that embraces it. Thus this part of Cutcliffe and Goward's (2000) argument is less convincing. Indeed, one may argue that the research endeavour is in part about pursuing a journey *for* certainty in terms of process and outcome. This can be seen when one examines the issues around the methodological framework chosen for this project – case study method.

6.2 The Case Study approach

John (2000) argues that much policy orientated research is descriptive, tending to eschew theoretical frameworks in favour of 'mapping' relationships and drawing conclusions about the nature of policy from this analytical process. A consideration of a number of the research questions posed and the framework in which they were located did indicate that this descriptive/ 'mapping' element (encapsulated in the number of 'how' and 'what' questions) was present within this study.[19]

Such a presence is an important component in any qualitative piece of research if one takes the view that contexts are important (and certainly were for this study) if analysis

[19] See Chapter 5, Box 5.2

is to be fully understood. Contained within the questions posed for this study, however, was also a significant explanatory element that required an analysis of motivational/ causal factors in the perception and operation of policy and *was* referenced to a number of theoretical stand points.

The conceptual framework and questions suggested both a current temporal and location focus was needed, as did the research questions, which focused on the understandings/ perceptions that affected organisational and professional relationships between individuals, CMHTs, management and the policy context. It was decided that a methodology based upon a case study approach would effectively 'capture' relationships, causal processes and explanations since it emphasises the holistic nature of a situation and therefore sat comfortably with the conceptual framework developed in Chapter 5.

It is acknowledged that a number of methods can be employed to examine such issues, for example evaluative studies have been undertaken to examine relational aspects of policy (Owen, 1998). However, the pertinence of case study was further emphasised by three factors. The first were the identified studies using Lipsky's (1980) perspective on street-level bureaucracy, the majority of which had utilised a case study approach (Protass, 1979; Wetherley, 1979), including the only empirical study utilising street level bureaucracy within a mental health policy context at the time this decision was made (Wunsch *et al.*, 1981).

A number of case studies were identified dealing with various policy and professional aspects relevant to this study that seemed to confirm the appropriateness of this choice (Cherniss, 1995; Hadley and Clough, 1996; Dopson, 1997; Bergen and While, 2000). Though it is striking that whilst all described themselves as case study, only the last specifically deals with the concept itself.

The second factor was discussions with colleagues at my place of work at the time and two colleagues who, utilising Yin's (1994) conception and procedures for case study, were conducting an examination of the role of district nurses as case managers (Bergen

and While, 2000). In particular, they highlighted Yin's (1994) view that case study should be used when the boundaries between the phenomenon of interest and its context are not clear, that the phenomenon is a contemporary one and 'how' and 'why' questions are postulated about occurrences over which the researcher has little control (Yin, 1994: 9-13).

A good example of this is a case study of a district general manager (Dopson, 1997) that described the relationships and difficulties he encountered whilst implementing mental health service changes, through contemporaneous observation and interviewing, rather than collecting data after the events had taken place. Because case study looks at the contemporary it is seen as a particularly suitable approach if one is interested in a process, describing contexts, populations and their relationship to such things as implementation which may provide an opportunity to investigate causal explanations (Merriam, 1998).

The third factor to influence my decision was the notion of 'case' and 'case' reporting. It is widely used in the discourse of mental health professionals and clinical research (Good and Watts, 1996; Morley, 1996). Indeed, some of the leading exponents of case study research come from a disciplinary background in experimental and clinical psychology (Yin, 1994; Bromley, 1986; Runyan, 1982). Thus the idea of 'dealing in cases' was familiar and sympathetic with my professional experience.

These factors therefore combined into a synthesis of attraction towards the use of case study. It was an approach sympathetic to my background, appeared to meet the needs of the study aim, sat easily with the study's conceptual framework and emphasised the contemporary context of the investigation.

6.3 Case Study method

A former colleague observed that "one cannot solve philosophical differences by concentrating on methods, but clarity of methodological approach goes a long way in

setting out the strength of a study".[20] This section therefore, sets out the conception of case study method used within this project.

I decided to conceptualise case study method as an examination of an 'instance' that can be seen as exemplar of an 'issue in context' in which questions of causality/ motivation can be explored with reference to theory. The considerations that led to this view, involved ideas on the importance of context as outlined by Yin (1994) with the concepts of the 'particular' (Stake, 2000), 'typicality' (Platt, 1988; Schofield, 2000), 'boundedness' (Merriam, 1998) and their relationship to generalisation as this relates to theory, particularly in relation to the development of theoretical propositions as 'signifiers' for the analytical process (Yin, 1994).

The first factor in planning this study, once having decided to utilise case study method, was to identify the specific elements that the method involved. The starting point for this was to define the meaning of case study method. A definition of what precisely constitutes a case study lacks a common consensus, with widely differing views as to the degree of prescription involved in its procedures and boundaries. Consequently, there is much debate about what actually can be 'a case', when one can employ case study as an investigative methodology and whether one needs to focus on a singularity or many.

These issues are intimately linked to a long established debate on the purpose of case study, its relationship to theory and whether case study can be utilised for the purpose of generalisation (Stenhouse, 1980; Bassey, 1999). Though a discussion of generalisation is usually found within a study's consideration of its validity these three issues are so bound up with the identification of case study method, that they will be discussed here inter-relationally. Further discussion of specific issues relating to validity or, more precisely in the context of this study, Miles and Huberman's (1994) formulation of *credibility*, will be addressed in Chapters 7 and 14.

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[20] Professor Sarah Cowley (2001) personal communication.

6.3(a) Defining Case Study as an approach

Case study is seen as an approach derived from the 'naturalistic' paradigm (Lincoln and Guba, 1985), though not exclusively so (Yin, 1994). It has been stated that it is the presentation and interpretation of detailed information about a single subject (Runyan, 1982) or 'instance' (Adelman *et al.*, 1980). It involves, according to Orum *et al.* (1991), an in-depth, multi-faceted qualitative investigation, using several data sources, of an instance or example of a wider social phenomenon. It is the holistic study of complex social actions, networks and meanings, allowing the researcher to examine social action in a real world setting. It can be used to obtain descriptions of contexts or situations as interpreted by those involved within them (Orum *et al.*, 1991; Stake, 1995). Blau's (1963) examination of office work is an early example of this.

Hamel *et al.* (1993) describe it as *a monographic* approach located within sociology rather than a method to be employed as a verification adjunct to statistical inquiry, the traditional view of case study within positivistic research. Merriam (1998) elaborates on this further by stating that a case study should be *particularistic*, that is have a specific focus, *descriptive*, that is a narrative 'thick' description of the interaction of variables, and *heuristic*, that is bring about understanding through either a discovery of new meaning, extending experience or providing confirmation of what is known, that gives an insight into how things get to be the way they are.

Within case study there is a commitment to understanding the meanings ascribed by the actors in a social setting through *their* descriptions of *their* behaviours and *their* articulation of the beliefs that underpin them (Hamel *et al.*, 1993). Hamel *et al.* (1993) argue that this should include the meanings ascribed by these actors to their own social experiences and social reality and that such study requires a depth and focus which case study can provide. Orum *et al.* (1991) support this view, arguing that case study can examine the impact of beliefs and decisions on social interaction and how people define situations. These views are significant for this study since the research questions seek explanations of perceptions and relationships that necessarily rely on the self-report of internal worlds and processes that can only be externally observed in operation in a very limited way.

Bergen and While (2000), amongst others (Merriam, 1998; Gomm *et al.*, 2000), point out that a clear definition of what constitutes a case study is more complex than these initial formulations might suggest. Ragin (1992) states that the problem is that the term 'case' is used in a variety of different ways. It can be a pedagogical device to explore decision-making or a means of exploring causality (Naumes and Naumes, 1999). It can be a 'test' of the implementation of innovative practices, policies and schemes prior to more wide spread application (Platt, 1988) or for the purpose of evaluation. It can be a general research strategy or as a method within a research strategy, for example its use as an exploratory device within survey research. Alternatively, it can merely be a rhetorical device - a means through which an individual chooses to discuss an issue.

Platt (1988) accounts for such differences by suggesting that its definition and purpose is re-interpreted by each discipline that comes to use it so that it reflects their philosophical orientation and purpose. It is this, she argues, that leads to ambiguity surrounding the term as method.

Merriam (1998), encapsulates this issue when she points out that the term 'case study' has come to mean a process, a unit of analysis and an end product. Indeed, the end product itself illustrates a further difficulty in coming to a clear understanding of what constitutes a case study (and perhaps illustrates why it is re-interpreted according to disciplinary orientation) since it can be a study of one individual, a number of individuals, a community, a social group, an organisation and/or a set of events, roles or relationships, programmes, policies, issues or theoretical perspectives (Robson, 1997).

The issue of end product as providing a definition of case study is related to its relationship to the degree that the case should be located in a wider context or seen as unique. Implicitly, this relate to whether and to what can a case study's findings be generalised.

6.3(b) Generalisation to theory

The act of generalisation, traditionally located within the positivist paradigm, is based upon inferences drawn from the statistical sampling of a given population. The

positivist view of generalisation is that it is context free and enduring (Lincoln and Guba, 1985). It is linked to the issue of external validity, which asks whether the findings in one study can be applied to other populations. In other words to argue that what one finds in one study can be applicable to situations outside of the particular study. Its purpose is anticipatory and to enable understanding (Eisner and Peshkin, 1990).

The issue of whether or not one can generalise from the study of a particular case is one of the central debates within case study (Becker, 1990; Gomm, *et al.*, 2000). Since generalisation is seen as central to whether or not a study has legitimacy, the fact that this remains a continuing issue of concern in case study could be seen as indicative of its manifold definitional interpretations as method. Thus the relationship between case study and generalisation is an important issue to consider as it helps to define the enquirer's understanding of case study as method and purpose.

A number of writers argue that case study can only generalise to theory (Yin; 1994; Eckstein, 2000). This position is particularly popular amongst writers whose original background was located in what might be characterised as more positivist disciplines (Psychology; Psephology etc.). According to Robson (1997) this sort of generalisation involves persuading the reader that it is reasonable to generalise from the results of one's study because of the group studied, the setting or time frame. However, what this actually means in practice is not as clear as a first reading might suggest and therefore needs to be carefully considered.

Hammersley *et al.* (2000) argue that case study can be used either to describe and explain the case or to develop and test theory. The former requires detailed description of the particular features of the case, whilst the latter requires cases to be selected on the basis of exemplification of theory. Vaughan (1992), alternatively, argues that case study does *not* test theory, though it can explore it.

6.3(c) Yin's notion of theoretical propositions

Yin (1994) states that the purpose of case study is to develop theory through analytic generalisation rather than statistical generalisation. Therefore 'the case' does not have to

be statistically representative, but needs to be representative in terms of an initial theory through which study can take place. Thus according to this view, case study lends itself to theoretical generalisation through either suggesting new interpretations or concepts or by re-examining earlier concepts and interpretations (Orum *et al.*, 1991). Yin's (1994) view of the relationship between case study and theory generalisation is the orthodox view and therefore his conception of case study requires further examination.

Yin (1994) believes that case study is "a comprehensive research strategy" (p.13), involving an empirical investigation of a contemporary phenomenon. In particular, he argues that case study, as a methodological approach is reliant on multiple sources of evidence, to investigate a range of variables, for the purposes of triangulation. He argues that case study method should be used especially when the boundaries of the phenomenon of interest and context are not clear. Because the boundaries of phenomenon and context are blurred, Yin (1994) argues that case study requires the development of what he terms 'theoretical propositions' to focus the study, since he believes that research questions in themselves are not sufficient to indicate what to study.

The purpose of such theoretical propositions is to provide guidance in terms of data collection and analysis and it is to these that it appears he argues one should generalise. It is important to realise that Yin's (1994) position on theory is not a deductive one, that is imposing a theoretical explanation on the data, but remains inductive since theory is used as a *guide* to data collection. For example, interpretative case studies are used to gather as much data as possible about a problem with the intention of analysing and interpreting this material in order to examine theory or develop new theories. Levels of theory conceptualisation in interpretative case studies, according to Merriam, (1998) can vary from 'suggesting relationships among variables to constructing theory" (Merriam, 1998:39). They are therefore often inductive in nature.

Taking these arguments in relation to this study for example would mean that reference to a contemporary policy context as a focus allows theory, in terms of that outlined in Chapters 4 and 5, to be employed to guide the case design, data collection and analysis,

whilst not imposed upon the data in terms of *testing* theory. Geertz (1973) in his discussion of the role of theory in the study of culture argues that one uses such theoretical concepts to 'scan' data for what he terms 'theoretical peculiarities' (p.26) that can provide signifiers for the analysis of social acts and discourse. Vaughan (1992) supports this position, stating that case study may use a loose conceptual model or theory to guide the research process. She argues that because more than one theoretical idea can be guiding a study, 'confirmation, fuller specification and contradiction may all result from one case" (Vaughan, 1992:175).

6.3(d) Case study as a predictive endeavour

Others argue that cases can embody generalisation in terms of causal *processes* in microcosm (Walton, 1992). Indeed, understanding the relationship between process and action, it may be argued, is part of the defining characteristic of case study. For example, the questions organised within the relational domains of this study of 'how' and 'why' something occurs may be seen as going beyond a cause and effect process, to one that implies an interactive process between individuals and contexts that requires the influence of motivations and perceptions on process to be examined. This is what Lincoln and Guba (1985) refer to as *mutually shaping*.

Commentators who take a social interactionist or neo-Meadian perspective, for example as encapsulated in human systems thinking (Checkland and Scholes, 1991), argue that human behaviours and responses are interactive in terms of developing a shared meaning through an interpretation located within a situational/ organisational context. Thus Lincoln and Guba (1985) argue that there are multiple constructed realities. The researcher strives to understand their interaction through a process of holistic inquiry and the interaction of inquirer and subject(s). The purpose of this is not to produce generalisations as to predictability as is the case in positivist research nor to distinguish cause from effect since, they claim, this is impossible due to the on going process of mutual shaping between individuals and groups over time in which it is no longer clear which caused which.

However, it would be naïve to think that the researcher does not come to some conclusions about generalisation and causality during the course of the research process that moves beyond the theoretical. Stake (1995) states:

> "To the qualitative scholar, the understanding of human experience is a matter of chronologies more than of causes and effects."
>
> (Stake, 1995:39).

This statement is not an outright rejection of cause and effect, but one of emphasis. It indicates the sequential element of personal and group processes and experience as providing an indication of cause and action. Ragin (1992) argues that causality can be assessed not in terms of an outcome that relates to the value of a variable, but an understanding of how activities come about. One might argue therefore that within this study my background as a mental health nurse provides an insight into *motivations for action* through an empathic understanding of individual practitioners' points of view, what German sociologists refer to as *Verstehen* (Eckstein, 2000).

A number of writers such as Abbott (1992) believe that notions of causality can, therefore, be considered in case study. Miles and Huberman (1994) look for what they term "causal descriptions" through an articulation of social and individual processes, structures and events, to explain phenomenon, what has been referred to as 'micro-mediation' (Cook and Campbell, 1979:32 *cited in* Platt, 1988:11). Orum *et al.*, (1991) argue that one needs to recognise such explanations in terms of identifying what they term *implied* cause and effect relationships. Becker (2000) argues this requires that part of the discussion of the case involves tracing the sequence of events leading up to what is to be explained.

If we consider this study, the points of analytical interest revolve around inter-dependency, subjective and inter-subjective frames of reference, interpretations of policies and their influence on and relationship to individual and group perceptions, relationships and activities within a real world/ temporal setting. As such there would be a notion of causality within these areas, not least in how subjects explained actions. However, ideas about causality in this sense cannot be deterministic in terms of developing predictive laws of outcome elsewhere. Platt (1988) for example, has argued

that if a case study is descriptively accurate and that its features are possible elsewhere then, " one can reasonably make generalisations from what one knows already until information inconsistent with this becomes available; whatever is true of one instance should also be true of other instances." (Platt, 1988:18).

The purpose here therefore is to recognize the features of the case that are likely to exist elsewhere, identified through the process of reviewing other policy and empirical literature, so that one can consider the degree of influence and operation of policy factors that exist within the particular case study that may help explain phenomenon noted elsewhere. In this sense generalisation is not referenced to theory, but rather to providing *insights* into issues that have been noted empirically elsewhere (Hammersley, 1992). What then appears to be the difference between this position and those who argue case study may only be used to generalise to theory is the issue of singularity and similarity.

6.3(e) Case Study, singularity and generalisation

Donmoyer (2000) states that the nature of the social world is a complex one, and particularly so where a study focuses on the world of interactive work that consists of a charged emotional and social environment, such as in health care. Donmoyer (2000) suggests that in such a context all research findings are uncertain or cautionary, regardless of the method employed to obtain them, because the results do not lend themselves to aggregates (See also Stake, 1995). By this, what one is arguing is that whatever the conclusions one comes to they have to be viewed as tentative because one is attempting to aggregate unique situations, instances and individuals that differ in many marked ways one from another. This can be seen when one looks at the limitations of statistical survey. The survey researcher has to presume that the answer to a single question accurately reflects that individual's attitude. Hamilton (1980) has characterised this as examining the social world through 'natural sciences' as opposed to case study, which he sees as looking at the social world through an interpretation of the 'artefactual'.

Case study as a holistic approach would extensively investigate the attitude of an individual on a subject; thereby ensuring that what is captured is the 'real' attitude of the individual (Orum *et al.*, 1991). It is for these reasons that case study has been viewed as a follow up adjunct to survey investigations or more particularly, as Eckstein (2000) argues, that because one is dealing with many individuals any theoretical conclusions that one may draw can only state positions about collective rather than individual actions. Indeed, it is in part for these reasons that Yin (1994), amongst others (Eckstein, 2000) believe that case study may only be used to generalise to theory.

One of the problems however in following the construct of generalising to theory as it is conceived by Yin (1994) is that there can be a greater value placed on the replication of cases, rather than strength of findings in the single case, as the means thorough which the potency of one's generalisation can be demonstrated. However, other writers argue that it is not the number of cases that is significant in determining the potency of one's generalisation but rather the degree to which one's case is representative of its 'class'. For example, Hamel *et al.* (1993) argue that the degree of representation depends on the relationship between the study aims and the case site. So long as the case site is carefully selected so that it is able to address the study aims, and that this is clearly detailed in the description of the case study, it is no longer a singular instance, but a concrete example. Therefore its methodological construction indicates its representativeness (Hamel *et al.*, 1993). In terms of the debate about methodological construction as it relates to singularity and generalisation (Simons, 1996) the position taken by Stake (1995; 2000) has come to assume an importance in the debate about what is case study method.

6.3(f) A critique of Stake's view of case study

Stake (1995; 2000) argues that case study as a research form is defined by an interest in individual cases. His emphasis is on the specifics of understanding the individual case rather than generalisation, since he sees 'the case' as a unique bounded system that is unlike other 'cases' (Stake, 1995). Consequently it cannot be representative. Thus it would seem that Stake (1995; 2000) has a very definite conceptualisation of case study in terms of scope – it relates to the specific and not the general– and nature – it is self-

contained. Stake (1995) argues that when utilising case study to deal with human services (e.g. health care, education) 'the case' is not an issue, theme or problem but an entity, such as a person, programme or group because it is composed of a system of inter-related individuals (Stake, 1995). He sees issues and problems as being within the case but not defining the case.

Taken at face value, the difficulty with this conceptualisation of case study is three-fold. First, it may limit the utility of interest in a case study to those involved in 'a case', those conducting the specific case study research and those who commissioned it, since it places restricted emphasis on the representational element of the case (Kennedy, 1979). Though this specificity of 'case' is perfectly valid, (Gomm *et al.*, 2000), it is of limited utility in terms of communicating to a wider audience. Second, it limits the sort of issues and problems that can be looked at since they are specific to one particular entity, thereby limiting the utility of the approach as a method of inquiry into issues and problems beyond that entity. It is perhaps not surprising, in this context, that much of Stake's work consists of evaluations of programmes in very specific educational settings (Stake, 1995).

The third problem with Stake's (1995) conceptualisation of case study is that it may reduce the importance of the context in which the unique is located as a consideration in inquiry since Stake (1995) argues that one need only consider the contexts in terms of the degree to which the case interacts with them. Thus he would reject, for example, Robson's (1997) contention that the definition of a case study is concentration on a specific case within a context pertinent to that case.

Stake (2000) himself acknowledges that his conceptualisation of case study is open to criticism. His more focused conceptualisation seems to be a reaction to what he sees as the dismissal of the value of studying the unique for itself in qualitative research (Stake, 2000:439). Stake (2000) does allow for wider constructions of case study than his initial conceptualisation might suggest, through his identified forms of case study (See Section 6.4). However, for him the purpose of a case is "not to represent the world but to represent the case" (Stake, 2000:448).

Stake's (2000) position is that because the nature of any given case is unique it cannot be used to indicate what may be occurring in other situations. This conclusion it appears is based on the notion of theory as related to causal prediction - that causal issues within the unique may only be pertinent to the unique, hence his argument relating to the consideration of context. Consequently, if one is to make generalisations at all, they can only apply to the particular case.

Stake's (1995; 2000) view is at some variance with a number of sociologists such as Hamel *et al.* (1993), who have a conception of the particularity of a case study as it relates to a wider generalisation. They argue the definitional purpose of case study *is* to place global issues in a local context. Ragin (1992) argues that in a broad sense every study of social phenomena that has a situational and temporal location is a case study, but can take many varied forms. It can be theoretical, empirical or both. It can be a bounded object or a process. It can be specific or general.

Walton (1992) argues that cases are more than a study of an instance; they are 'cases' because there is some sense of generality, that "the particular is a case of something else" (p.121). Thus Platt (1992) states that within historical study there is a long tradition of looking at a particular individual or group as an exemplar or focus of the nature of a particular situational issue or context. These authors do not appear to dismiss the importance of studying the unique but do argue that the meaning of the unique can only be fully grasped with reference to its wider context.

Yet in a sense Stake (1995) does appear to accept such opinions when he argues for what he terms '*naturalistic generalisation'*, in which the data and conclusions within a case study resonate with the reader's experiences and *a priori* knowledge. Stake (2000a) advocates intuitive or naturalistic generalisation in which familiarity with the case interacts with the experience of the individual so that the reader is able to recognise similarities between objects, both in familiar and unfamiliar settings. He believes that during the course of reading an inquiry the reader of a case will generalise it to other settings with which they are familiar. However, he does not make clear whether or not

the case researcher can make explicit such generalisation within their account or whether this has to remain tacit.

A number of writers are critical of Stake's (2000a) position on naturalistic generalisation in terms of its utility. Donmoyer (2000) points out that Stake (2000a) fails to indicate how this form of generalisation can be used to 'act more intelligently in other potentially different cases' (Donmoyer, 2000:54). In a similar vein, Lincoln and Guba (1985) are critical of Stake's (1978) formulation of naturalistic generalisation on the grounds that it does not indicate how a reader is supposed to assess whether or not the naturalistic generalisation applies to their situation. They state that whilst they see it as having some merit, more explicit expressions of generalisation are important. They argue for what they term '*transferability*', '*fittingness*' and '*holographic generalisation'*, based upon the concept of the working hypothesis, with *tentative* generalisation being an outcome (Kennnedy, 1979).

6.3(g) Generalisation through 'Transferability' and 'Typicality'

As indicated in the discussion so far the concept of nomic generalisation is not a characteristic of case study, rather it can be argued generalisation is identified from within unique local conditions (Lincoln and Guba, 1985). Lincoln and Guba (1985) state that the local, so long as it has many of the features of other potentially similar cases, what they term 'typicality', need not be statistically representative but can be taken to represent the wider picture, just as each piece of a holographic film negative contains all the information to reproduce the entire image exactly, no matter how many pieces into which that negative is divided. The inquirer indicates the transferability of their conclusions to other environments through what they term 'thick description' (Geertz, 1973), that is providing sufficient detail of the context of the unique to allow another individual to form a judgement about the degree to which conclusions are *transferable* to other similar environments.

Developing these ideas further, Schofield (2000) states that generalisation within qualitative research is not about producing universally applicable laws, but rather to provide information that may help form judgements about other situations. To do this

she believes that qualitative researchers need to think about generalisation in terms of 'to what do they want to generalise' and does the design of their study maximise generalisation in these terms. In order to do this she argues that one needs to choose a case site that is *typical* of its class or situation and that typicality combined with thick description provides the reader with sufficient information to make an informed judgement as to fit and thereby enhances generalisation

However, Gomm *et al.* (2000) argue that 'typicality' is insufficient for generalisation to take place. They state that individual case studies cannot be generalised, but rather require comparative investigation with other cases to achieve this, though one needs to emphasise they are not arguing for statistical sampling/ representativeness of cases in this context. However, whether or not one needs to have a number of comparative cases to achieve generalisation depends on how one conceptualises the term 'case'. That is whether one is using the term 'the case' as a holistic unit of analysis, or whether one is talking about the case consisting of levels or a number of units of analysis. If the former then it appears that Gomm *et al.*'s (2000) view maybe valid; however if one conceptualises analysis of 'the case' in the latter way then one may conduct comparative analysis 'within case' that can lead to generalisation, particularly when that case is dealing with an issue.

For example, because this study focuses on individual and group relationships and how they affect policy, one would need to look, within the case site, at the views and perceptions of individuals and groups 'within case', and engage in a 'within case' comparative exercise. This was the strategy that was followed (See Chapter 7). Since many of the individuals and groups to be found within 'the case' site, for example community mental health nurses and psychiatrists, also exist in other mental health case sites one may well draw conclusions that will 'transfer' or have 'fit' to these individuals and groups beyond the specific case. Certainly, it is the responsibility of the inquirer to point out the specifics of the case that need to be taken into account that might counter-argue such generalisation, for example atypical features of the site/ context, which is precisely what writers such as Schofield (2000) suggest in their use of the term 'fit'.

6.3(h) A consideration of generalisation and theory in defining 'the Case'

The difference between the positions of those who utilise case study appears to be the degree that the inquirer can communicate explicit generalisation and the breadth of generalisation. Case study within the debate on generalisation seems to be defined as a study of the particularistic but not necessarily the unique. Uniqueness is dictated by the degree to which the particular contains typical features of similar potential cases. 'Typicality' then places an emphasis on the internal features of the case in terms of comparability. Comparability in this construct can be negotiated internally, that is comparing features within the case against one another, and externally, comparing these features with features identified within similar contexts external to the case. The degree of typicality dictates the degree to which and to what one may generalise.

The level of particularity versus typicality also dictates the degree to which context can be separated or intrudes upon 'the case' and therefore whether one should utilise theoretical propositions to both guide the data collection and analysis but also to more specifically refine 'the case' as the study focus. The construction of 'the case' therefore indicates typicality and purpose. Platt (1988) points out that issues of construction can be neglected in the presentation of case study. Yet delimiting the case, with generalisation, is the second factor in defining case study method.

6.4 Delimiting and identifying 'the Case'

Stake (2000) identifies three motivators for the conduct of case study, the degree of the presence of each it might be argued, determines the construction of 'the case'. The first he calls *intrinsic* – in which a researcher has a particular interest in coming to an understanding of a particular 'case'. The second is *instrumental*, in which a case is examined in order to provide an insight into an issue or "redraw a generalisation" (p.437). Stake (2000) sees the boundary between these two forms of case study as based on the final product rather than in terms of experienced process, since the researcher interested in the particular is also likely to have general interests to which the case may also be applicable.

The final form of case, Stake (2000) describes as *collective*, which is an instrumental study of several cases, the purpose of which is to better understand or theorise about a larger collection of cases. It is notable, that in all three forms and particularly the *collective* Stake (2000) remains faithful to his original conceptualisation of uniqueness, identifying a collection of *cases* rather than a *wider case*. Of these three 'types' of case study, it was the first two and, in particular, the *instrumental* case that seemed the most apt categorisation of this case study because of my development of a conceptual framework and use of theoretical propositions (see below and Box 3.1).

Merriam (1998) argues that delimiting the object of study – 'the case'- is the defining characteristic of a case study. This exercise assists in determining its boundaries, the inclusion/exclusion criteria for data collection and identifying data points (Guba and Lincoln, 1985; Bergen and While, 2000). However, defining the boundary of this study was one of the most difficult aspects of coming to grips with the case study method. Initially I was not sure whether 'the case' was the process of relationships, mental health policy itself, the groups of professionals implementing mental health policy or the organisation of the policy process; though my dilemma did seem to illustrate Yin's (1994) point about the boundaries between phenomenon and context being unclear.

Identifying the boundary of 'the case' was an important issue because it had implications not only in terms of data collection, but also in terms of whether or not case study should be used at all. For example, Merriam (1998) states that the 'boundedness' of a topic is the degree that data collection is finite, and that this is a test of whether or not the case study approach is suitable for the particular research endeavour.

The literature on the subject initially proved to be somewhat unhelpful as an aid to resolution of this issue since views differ as to whether the definition of 'the case' within a research study should be emergent through being 'in the field' and identified by key informants, or imposed by the researcher (Bergen and While, 2000). Yin (1994) takes the latter view and argues that 'the case' can be such things as decisions or the implementation process.

Bergen and While (2000) have pointed out that Yin's (1994) definition of what can constitute 'a case' is wider than that advocated by Stake (1995), who believes that it must be a specific individual entity, such as a person, group, or organisation. This aspect is at heart an ontological one in which one needs to ask whether a case exists of itself waiting to be 'discovered' or is it created through the agency of the enquirer (Bromley, 1986). Both Yin (1994) and Stake (1995) seem to concur that the researcher defines 'the case' externally.

Within this case study this issue was dealt with by differentiating between individuals, one might see as existing as 'cases' independently of the researcher, and issues/ problems, which are identified and externally defined by the researcher as 'cases'. In the latter the researcher engages in an active process of 'case creation' by defining boundaries, contexts and identifying/ tracing relationships that may be significant to the issue. This is an act of creation because the researcher is obliged to make an argument as to their rationale for what they decided to include within 'the case'. It is this latter construct that one might see as the ontological characteristic of this case study.

6.4(a) Differentiating 'the Case' from the context

Bergen and While, (2000) criticise Stake (1995) for lack of clarity on the issue of how one differentiates 'the case' from its context, whose views they compare to those of Yin (1994), who argues that because the boundaries between case and context can be unclear, context needs to be included in the case, though treated differently for the purpose of analysis. However, this criticism of Stake's (1995) comparative lack of clarity seems somewhat unfair, since they themselves acknowledge that Yin (1994) is vague about how context can be both included and treated differently in analytical terms. In addition, Stake (1995) it appears, whilst arguing for the need to ensure that the entity of the case is 'bounded' does acknowledge that context needs to be considered and in his views on the fluidity and elusiveness of the case displays a certain congruence with Yin's (1994) ideas.

Within this study the entities and implementation process were so intimately linked within the research question that it was decided to reject Stake's (1995; 2000)

conceptualisation of the case as exclusive entities such as groups or individuals. Instead Yin's (1994) wider view that context should be conceptualised as a specific element of 'the case' was adopted.

In fact thinking about issues of context helped to define what 'the case' boundaries were as an object of study because it led to a consideration of my previous work that had initiated the study interest (See Chapter 1 and Section 6.1). Hamel *et al.* (1993) argue that the object of study is defined through a process of establishing ties with the field, consistent with an inductive approach. This is seen as a preliminary part of the research process once a study has begun. However, health care professionals conducting research often have established ties with the field that can provide an insight into the object of study prior to the start of a project. This was so in this study. Thus a consideration of *a priori* knowledge, the study questions and conceptual framework suggested two things – the first was that the conceptual framework needed to be further explicated and second, that the conceptual framework could form the focus of 'the case', but needed a further refinement to take account of its inclusion of contexts.

The conceptual framework (Chapter 5, fig.5.1) indicated that it had a heuristic dimension, in which phenomenon could be explored with reference to theory, such as that proposed by Lipsky (1980) and Fisher (1998), in terms of operation and development (Mitchell, 2000). However, additionally, the concept of 'typicality' and 'transferability' meant that generalisation might be made from the case study, should this be suggested by the analysis, so long as the descriptive element was sufficiently 'thick' and a 'within case comparative' construction of 'the case', in terms of, data collection and analysis was used.

Taking these factors into account it seemed appropriate to draw out the theoretical propositions (See Box 6.1) contained within the conceptual framework. This was an iterative exercise to assist in the clarification of the case focus and in terms of structuring a guide for data collection instruments, for example in terms of interview guide and range of data points.

A) Policy may be an attempt to delimit risk.

B) Policy ambiguities are left for managers and practitioners at local level to negotiate

C) Service organisations will often act in ways that appear contradictory to policy.

D) Individuals will experience conflict between their personal values/role conception and some of the priorities they are required to implement leading to a sense of alienation from policy and their employing organisation

E) Individuals, teams and organisations will focus on meeting explicit priorities at the expense of non-emphasised activities.

F) Practitioners and teams will develop routines and processes to deal with dilemmas set up by policy ambiguities and conflicts.

G) Individuals and teams will attempt to convey an image of esponsiveness in order to deflect criticism arising out of resource constraints.

H) Individuals and teams will manipulate policy priorities by non-operation or utilising their boundary spanning positions to influence information about policy

I) The interaction between individuals within the team will shape team responses to policy

J) Individuals will rationalise their perceptions through the use of heuristics that change in relation to the pressures to which they are subject

Box 6.1
The theoretical propositions within this study

Whilst theoretical propositions are useful in terms of clarifying thoughts they pose a dilemma in terms of fidelity to the inductive process one subscribes to within qualitative research. Therefore it was important to be conscious that the theoretical propositions aid to focus thinking on generalisation to theory, but were not there to be imposed on the data. Neither were they to be used in terms of 'testing' theory. An attempt to deal with this issue was made in the design of data collection and analytical methods (this will be discussed in Chapter 7).

Through this iterative process a unifying descriptor, informed by *a priori* knowledge, linking the surveyed literature, theory, the conceptual framework and the theoretical propositions was sought that would, in effect, be 'the case'. The result was a 'case statement:

'The case' is the relationship between policy and actors within community mental health services.

This statement captured the notion of relational aspects through levels and intersections as suggested by the conceptual framework. It captured the notion of context in relation to policy, whilst the term 'actors' carried connotations of motivation related to perceptions and actions. Reference to community mental health services provided the necessary element of 'boundedness'. The connection of 'policy', 'actors' and 'community mental health services' through the use of the word 'relationship' conveyed the notion of the study of the particular within a wider context.

6.5 Utilising 'the case' boundaries to identify 'the case' object for study

Both Yin (1994) and Hamel *et al.*, (1993) argue that the case boundaries should be dictated by the research issue, but that generally the researcher should seek out a case that represents the issues of interest. It was this counsel that was followed. The boundaries of 'the case', utilising the conceptual framework as a guide,[21] were therefore located within CMHT services. This would facilitate an examination of interactive processes between individuals, groups and organisational structures and policy.

Though the boundaries between context and the case were unclear, for example the extent to which managers are creators of context as opposed to part of the context or subject to pressures from the context, it appeared that the context should be central government mental health policy and the agency and stakeholders charged with conveying this policy to the local community mental health service. This was because the study asked, in part, how groups and individuals in the latter dealt with the former and each other. On the other hand the boundary of the object of study would be the community mental health service at local level, and those elements within it that were most likely to be the focus of policy activity - community mental health teams (CMHTs).

One other area that required consideration in terms of boundary was the issue of time frame. This only became a conscious issue of boundary following data collection; nevertheless its significance in terms of effect on the analytical conclusions, particularly in terms of generalisation, need consideration.

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[21] See Chapter 5, fig.5.1

6.5(a) Temporal dimensions of case study

Gomm *et al.*, (2000) point out that inquirers in case study rarely make clear the temporal boundaries of the case, arguing that this weakens claims for generalisation about the phenomenon in terms of what has gone on before data collection and what will occur after data collection. This is an important issue for this study because mental health policy, at least at a superficial level, has changed markedly since 1997, when the data was collected. Therefore, some of the concerns expressed about specific policies may have changed as the climate surrounding the operationalisation of particular polices, such as Supervised Discharge, changes. However, it needs to be borne in mind that this is a case study *not* of a specific policy, but rather of relationships between groups, individuals and policy.

Therefore the case issue is not time specific, rather the time context is used to examine, explore and illustrate wider issues that may well have a relevancy to current practice and policy, since though policy has changed the controversy surrounding mental health policy and its relationship to practice has not (King, 2000). Thus there continue to be certain themes that have remained constant, such as 'value for money', delegating accountability to practitioners, the 'political' sensitivity surrounding services to the mentally ill in the community, relations between professions and agencies, levels of work load and levels of access (House of Commons Select Committee on Health, 2000).

What the temporal boundary illustrates is the importance of fully explaining the content and focus of national and local policy and events at the time of data collection (See Chapters 1, 2, 3, 8 and 9). Through such 'thick' descriptive procedures the reader will be able to judge the degree to which this study's conclusions were affected by the temporal dimension (Gomm *et al.*, 2000).

6.6 Drawing generalisation and boundaries together to define Case Study as Method

Overall, for the purpose of defining case study method in this study, a combination of views on the method was used rather than 'slavishly' adhere to one view alone. Yin (1994) was used to develop the structures that underpin the study, particularly his ideas

on the use of theoretical propositions and the importance of the relationship between case context and case. His approach emphasises the need for clarity in structuring one's study, though it is quite positivist in tone and therefore seems at odds with his commitment to inductive enquiry. His view that case study can only generalise to theory is drawn from his overall positivist philosophy because case study, he argues, does not strive to be statistically representative.

Yin's positivist background also explains his tendency to emphasise multiple case study design in order to strengthen generalisation. The potential for confusion resulting from Yin's (1994) overall positivist tendency is indicated in his adherence to the concepts of 'validity' and 'reliability', which it is now well recognised are problematic when applied to qualitative research (Lincoln and Guba, 1985)

As a corrective to these positivist confusions within Yin's (1994) work Stake's (2000), view that there is value in studying the particular was incorporated, even though he rejects the possibility of explicit generalisation as an outcome of case study. However, he does argue that generalisation can take place vicariously through the interpretations placed upon the case by the reader.

Whilst this 'naturalistic' generalisation can and does take place it ignores the reality of the research process, which is that the researcher is likely also to come to conclusions about relationships and causalities that have resonance with their wider world view, and which are at the core of generalisation. Consequently these should be made explicit (Becker, 1990). Therefore, the concept of 'typicality' (Schofield, 2000) was adopted. This emphasises that generalisation from a specific bounded case can take place so long as the components that are studied in relation to the case are 'typical' of their class within the wider context. In this sense one may make generalisations that whilst not statistically representative may nevertheless provide 'insightful' conclusions as to the behaviour of 'like classes' outside the specific case.

Becker (1990) argues that, "each case, potentially, represents different values of some generic variables or processes" (p.240). From this perspective one may argue that this

case study may provide an insight into the processes that are likely to take place amongst similar classes or settings within the relationship between policy, actors and community mental health settings, whilst acknowledging that the specifics of their context will create variations in outcomes (Becker, 1990). This in a sense brings the reader full circle to the beginning of this Chapter and the idea that people's experiences are multi-dimensional and interpretative (Geertz, 1973). Within this case study these are placed in relation to levels of context.

6.7 Conclusion

This Chapter outlined the process involved in choosing a case study approach to investigate the relationships and attitudes of individuals within local mental health services and how these affect policy at local level. This choice of approach was a result of and intellectual process of discovery.

The inter-relationships between *a priori* knowledge, reviewing literature, formulation of a conceptual framework, research aim, questions and theoretical propositions involved in this process can be represented in terms of an interchange of ideas as thought and reading progressed. This finally resulted in an integrated concept of 'The Case' (See fig.6.1).

However, development of thinking in terms of design did not come to an end once the general picture for the research method had been sketched out. For example, some thoughts about boundary, such as temporal thinking, occurred after data collection 'in the field' had been completed. It might also be argued that theoretical propositions should have flowed from the conceptual framework, before aims and questions were formulated. Reflecting on this has led to a conclusion that in fact these elements were more enmeshed than at first realised. The theoretical propositions were already implicit in my review of Lipsky (1980) in particular. What my reading on generalisation and case study (e.g. Yin, 1994) led me to do was to make explicit what was already implicit.

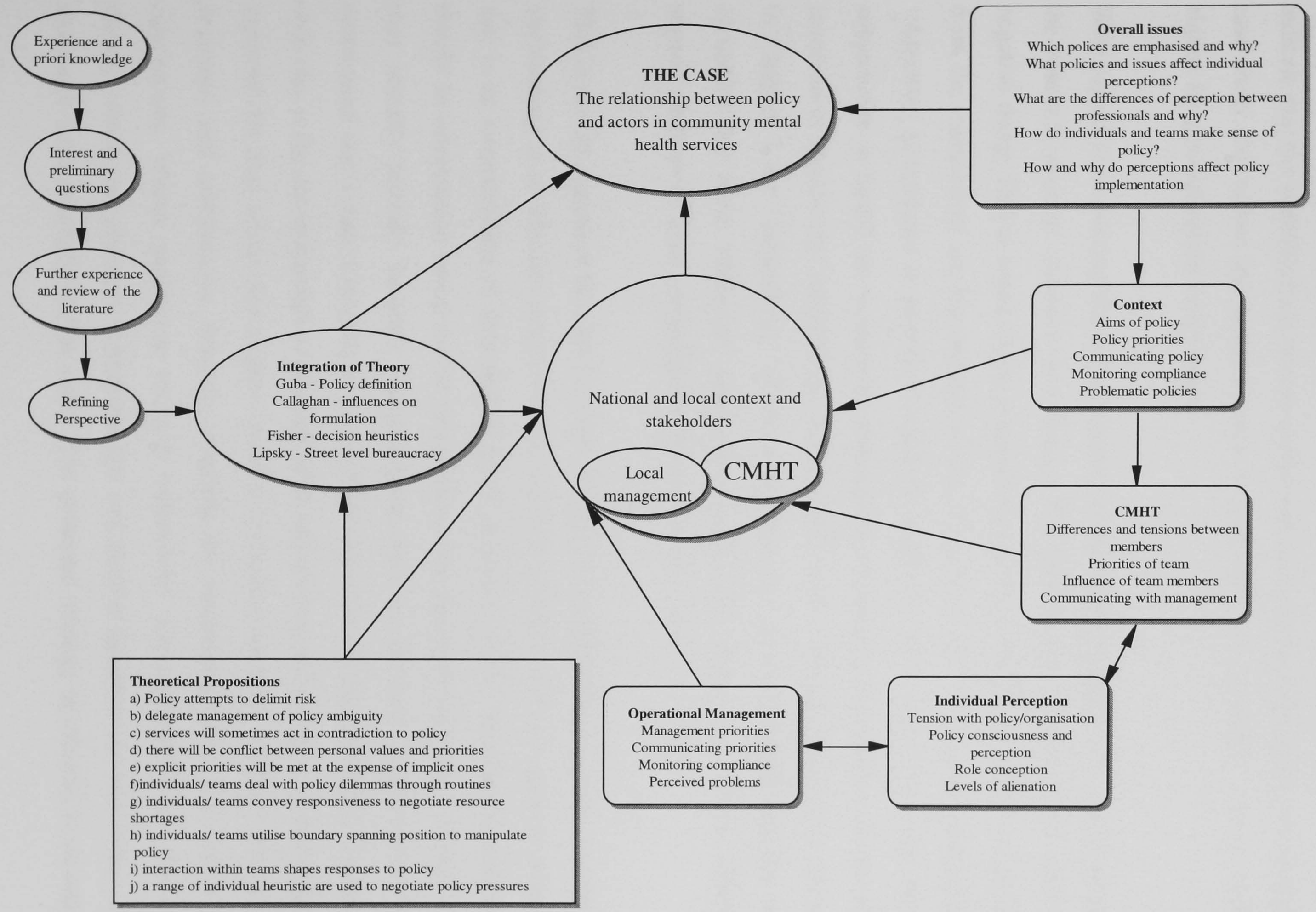

Figure 6.1
A conceptual model of the development of 'The Case' and its component

Two criticisms can be made of case study as a basis for traditional conceptions of generalisation, also known as external validity. The first is that it is unrepresentative because of its singularity, and therefore one may not generalise from its results. Secondly, that it is prone to bias because it deals in the subjectivity of researcher and field informants (Hamel *et al.*, 1993). In the first instance this Chapter attempted to indicate that the statistical test of representativeness is not an appropriate one to apply to case study, but rather one needs to look at it in terms of 'typicality' and to what are claims for generalisation being made.

With regard to answering the second criticism, the view of subjectivity and its effect on the research process assumes two things. The first is that 'subjectivity' itself is a negative thing. This is based on the assumption that the findings of a study, which result from the 'subjective' are less certain or 'true' than those that result from the traditional 'objective' procedures in positivist research. Kemmis (1980) argues that this view of subjectivity is based on 'scientism' rather than a careful consideration of the issues involved in objectivity/ subjectivity. As indicated in this Chapter and further discussed in Chapter 7 the 'subjectivity' of the researcher can provide insight into the issues identified that more 'objective' approaches might miss. Indeed as Philips (1990) has argued, objectivity does not guarantee that results are certain or 'true'.

This is not an argument that the concept of objectivity should be discarded but rather a questioning as to whether subjectivity in research should always be equated with bias, that is an interpretation of data derived from prejudice or pre-formed schemata which results in information being forced to conform with preconceived ideas. 'Subjectivity' may actually provide 'insight', drawing upon previous personal experience to better understand one's data. Certainly bias can flow from the subjective but the way to deal with this is for the researcher to attempt to be self-aware, self-critical, acknowledge the potential for bias where this might exist and to explain fully the rationale for research decisions and conclusions, honestly detailing the research process that led to such conclusions. Within qualitative research 'reflexivity' and auditability are the means through which one attempts to indicate this and thereby demonstrate objectivity. These issues are acknowledged in this study. The principal strategy developed to incorporate

subjective insights ('*verstehen*') whilst guarding against and limiting bias are indicated in Chapter 7.

Criticism that the sample in case study may lead to bias can be answered in three ways. The first is that one looks for 'typicality' within the singular. The second is that all sampling may be biased, for example, differences between individuals who choose to answer a survey and those who do not. Therefore to reject data from informants on these grounds could stop much social research. Thirdly, one can attempt to ensure that one view is not overly represented through a comparative analysis of the *range* of informants' views.

In conclusion, the issues of case construction, subjectivity and their relationship to what can be learned from a case study beyond the particular relates to the practicalities of site selection, sampling frameworks, data collection and analysis. It is these areas as they were developed in this case study that will be discussed in Chapter 7.

CHAPTER SEVEN

Process of Investigation

7.0 Introduction

Within case study the procedures for gathering, analysing and presenting findings are not prescriptively laid down but are a reflection of individual perceptions of what is needed to investigate 'the case' (Simmons, 1980). As such it is incumbent upon the case study researcher to carefully outline the procedures adopted, their rationale and use and the reflexive elements that affected this process. This Chapter describes the research process and the reflexive elements that affected decision-making.

Section 7.1 discusses the factors that influenced the decision to develop a single case site design, whilst Section 7.2, sets out the process followed to identify an appropriate case site. In section 7.3 the dilemmas in gaining access to the case site in relation to the role of 'gatekeepers' and protecting participants is described and discussed. Section 7.4 outlines the development of a sampling framework for investigation of 'the case' within the case site.

Section 7.5 describes the data collection instruments and Section 7.6, discusses the issue of reflexivity as it affected the investigation. Section 7.7 discusses the influences on the choice of analytical procedures, which is followed in section 7.8 with a description of the Frameworks Analysis approach adopted and applied to the data. Section 7.9 concludes with a reflection on the research process as a whole.

7. 1 Factors affecting the choice of a single case site design

The literature on case study often fails to differentiate the three components that are encompassed within the approach -'case study', that is the methodological approach; 'the case', that is the object of study and the 'case site', that is the place where 'the case' will be examined. In particular, it is important to realise that the latter two are not

synonymous, particularly as they relate to sampling and data analysis. For example, both Yin's (1994) discussion of multiple case study design and that of Miles and Huberman (1994) are actually discussions of multi-site design, in which 'the case' is investigated in a number of similar environments.

A multiple design is either an application of sampling logic, in an attempt to achieve confirmation or replication for the purpose of generalisation, particularly emphasised by Yin, (1994); or refinement in terms of theory building. What it is not is an attempt to investigate many 'cases', as this would be the methodological equivalent of comparing 'apples' with 'oranges'. A more accurate description of this multiple design would be 'multi-site' as opposed to 'single site'. In this section, the reasons for the selection of a single case site design to investigate 'the case' in this study are discussed.

As indicated in the previous discussion of case study method and generalisation[22] the consensus on qualitative case study indicates that a singular case design can be appropriate for analytic generalisation if the case site is carefully selected (Simmons, 1996). Cases may also be selected not on the basis of representativeness but for the purpose of illustration and illumination (Wilby, 1980; Vaughan, 1992).

Miles and Huberman (1994) state that the practical consideration of available time for data collection needs to be factored into any consideration of how many sites one should access. An important factor in this study was time in relation to work commitments. My teaching and administrative workload entitled me to one day off per week to conduct research. This factor would only allow for regular contact and collection of data in any meaningful depth from one case site.

A single case site design was chosen, where the site had 'typical' features of its class (See Box 7.1) and was likely to reflect the issues of interest (Schofield, 2000). This does not preclude the fact that there will be elements within a case site that will be 'a typical' (Schofield, 2000). These elements may nevertheless provide valuable insights into broader issues.

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[22] See Chapter 6, Section 6.3

7.2 Selecting the case site

Stake (2000) argues that one should select a case site on the basis of the one from which the researcher feels they can learn the most. He goes on to state that this often means taking the most accessible case and the one with which one can spend the most time.

Since I worked and lived in the London area it seemed appropriate to focus on community mental health services in that city. London mental health services were often the subject of debate in the media and therefore were likely to provide good exemplars of wider issues.

I had good relationships with both managers and clinicians in one of the mental health trusts in London that served both inner and outer London boroughs and had a well-established community mental health service, as I had previously been employed in the Trust as a ward manager. Such contact eased access because significant 'gatekeepers' knew me.

Typical Features of Case Site	**A typical Features of Case Site**
NHS Trust	National and regional specialist units
Operation in internal market	Trust part of a medical school
CMHTs	Nationally known clinicians
GP fundholding	

Box 7.1
Typical and A typical features of the case site

The Trust functioned within the parameters of the 'internal market' and the health district with which it had contracts also contained both fund holding and non-fund holding GPs. Thus this service coincided with Stake's (2000) view of *accessibility* and *familiarity* as indicators of whether or not one could learn most about a case site and met Vaughan's (1992) view of suitability in terms of its potential as an exemplar of mental health issues in London. In this sense therefore it was 'typical' within Schofield's (2000) frame of reference (See Box 7.1).

7.2(a) Atypical features

The site's 'a typical' features were that it provided a number of nationally and internationally recognised specialist in-patient services unlike the majority of mental health trusts in the country. It was also a Department of Health pilot site for an 'assertive outreach' team (Burns and Guest, 1999). This might affect generalisation. Since however, it has been recognised for some time that single site case study, even when used for the purpose of providing generalisation to its class, will move from being typical to unique (Adelman *et al.*, 1980), this atypical feature provided an opportunity to cast further light on the relationship of local to national policy as the outreach team focused on SMI in the community and therefore would need to liase with CMHTs.

7.3. Negotiating access to the case site

There were three levels of access to negotiate within the case site – executive management, clinical management and CMHT members. Discussions began in August 1996. The first person approached was the Deputy Chief Executive of the Mental Health Trust. He readily agreed to support the research. He suggested that the Chief Executive of the local purchasing authority be contacted to get their approval. On reflection it was significant that he felt he needed their approval before he could sanction access to the Trust, indicating a certain 'political' consciousness. The Chief Executive of the local purchasing authority also agreed to collaborate with the research, once she had heard the Trust was supportive.

During the course of the meeting with the Deputy Chief Executive I discussed my sampling intentions, for example the intention to interview a range of Trust managers.[23] At this point he suggested the two CMHTs and suggested that a meeting be arranged with the two respective consultant psychiatrists and the Trust chief nurse adviser.

On reflection, it was probably an error to have so readily gone along with this proposal. Management nomination of the CMHTs potentially projected the message that the research was associated with a management agenda, rather than independent, and may

[23] See Chapter 10 for an account of how this group was accessed

have contributed to a sense of mistrust with which I was initially greeted by CMHT B and a number of its members, who subsequently avoided individual interview.

This incident illustrates a difficulty that can arise when 'insiders' conduct research. It is generally recognised that whilst there are advantages to 'insider' research there are also disadvantages such as one's relationship with colleagues and/or potential for bias. Generally, 'insider' is defined as someone working within the research setting (Robson, 1997). However, an 'insider' may not necessarily be employed within the research setting, but rather be seen as an 'insider' through previous contact. This was so in my case. Despite the fact I was no longer an employee of the Trust, the relaxed and co-operative manner with which I was received indicated that I was seen as 'one of us'. At the start of the project this did not seem problematic, however, it became more of an issue when observing the CMHTs (See Section 7. 5(d) and Box 7.5).

A joint meeting with the two relevant Consultant Psychiatrists and the Chief Nurse Adviser was arranged. This meeting was less relaxed than the previous ones, with one psychiatrist in particular closely questioning the purpose of the project. Nevertheless access to the CMHTs was agreed.

7.3 (a) Ethical issues in relation to gate keeping

There was an ethical concern with regards the way access was granted. Access was granted to meetings where meetings involving additional people to those who had agreed access would be observed. The 'gatekeepers' held positions of power in relation to such people. These individuals, whilst in a position to refuse to be involved with the project in terms of personal interview, were placed in a position where it would be difficult to refuse being observed in meetings.

This issue was addressed through negotiation of access at a third level, by visiting each CMHT three weeks prior to the start of observations to give information about the research and provide an opportunity to be questioned. The right of all team members to refuse an interview was stated and the members were told that reporting of observations of meetings would be done thematically, and not by individual. However, from an

ethical point of view, this was an unsatisfactory element within the access seeking process.

7.3 (b) Seeking ethical approval

The ethical complexity of research in a clinical area requires consideration of: the research design; access, consent and researcher role; and anonymity and confidentiality for the participants (McCosker *et al.,* 2001). I assumed that I would need to seek ethical approval from the hospital's ethics committee before I embarked upon the study. However, I was informed that the ethics committee did not think it had a role in relation to my study as it did not involve contact with patients. Therefore the project was not subject to outside scrutiny beyond that of my supervisor. McCosker *et al.,* (2001) argue that in such circumstances safety guidelines need to be developed at the beginning of a research project to identify and minimise risk.

The primary risk to participants in this study was a potential threat to employment should anonymity be compromised. Therefore it was decided that the organisations concerned in the study would not be identified beyond stating they were London based and participants anonymised. Appropriate written information and time for reflection on the part of respondents was given prior to interview (usually two weeks before the projected date), through the supply and receipt of a written consent form (See Appendix C).

7.3 (c) Protecting individual participants

McDonnell *et al.* (2001) state that when interviews are conducted with subjects within their familiar surroundings they may treat the researcher as a guest whom they feel obliged to help as a matter of courtesy. This may lead them to disclose material they would not normally reveal. McDonnell *et al.* (2001) argue that this could be a violation of autonomy. They argue that the way to deal with this is to engage in an on-going dialogue with participants to check for consent. However, they do not address the issue of who decides when autonomy has been violated in these particular circumstances and what to do if such a conclusion is reached.

McDonnell *et al.*'s (2001) concern somewhat undermines the purpose of entering 'the field', which is to gain access to social meanings and perceptions. Indeed, the implication of developing a 'truthful' account is put at threat. The important issue for autonomy is how the researcher respects it through the handling of such information. If it is not relevant to the research it can be safely ignored. If it is of relevance then its use needs to be managed carefully with reference to the principle of non-malfeasance - avoid doing the individual harm (Beauchamp and Childress 1994). An example from this project will illustrate the point.

A participant revealed that she invented patient contact hour returns whenever she feared she might fall below 'Trust' targets. This provided an important insight in how scrutiny pressurises street level workers' actions to distort policy implementation through their information giving.

The revelation came about as a consequence of regular contact time with the CMHT (over a period of three months), my own professional background in mental health, indicating a possible empathy with her problems, and a resulting general sense of trust prior to and during the interview process. In particular my promise not to identify sources was important in this regard.

Her revelation did not appear to come about as a consequence of an obligation of hospitality. To reject this information would have rendered an important consideration in coming to an understanding of the processes and pressures influencing the responses of some individuals and CMHTs redundant. Indeed, to reject such knowledge, once aware of it, from the case study account could be seen as affecting its 'truthfulness'.

Conscious of a responsibility 'to do no harm' to the participant, careful consideration was given as to how the revelation should be used. As a consequence verification from other sources was not sought from the rest of the CMHT, since asking for verification could raise suspicions that a member had admitted to such activity[24]. This was not a problem in terms of analytical confirmation since the focus was on discovering the

[24] Indeed throughout this time I never identified to anyone else who had or had not given me an interview, always ensuring that approach and arrangements for such took place away from colleagues.

range of phenomena rather than looking for representation. Secondly, in terms of depiction the verbatim record was carefully examined to see whether it might reveal the participant's identity. It did not. Consequently, text could be quoted for illustrative purposes whilst not compromising anonymity.

7.3 (d) Data product and ownership

The issue of who 'owns' data - the researcher or the subject - is an important one (Morse 1998). Returning data (for example tapes and transcripts) to participants is suggested as one ethical way of dealing with product but may prove impracticable (Morse, 1998). This was certainly so in this study as once data had been transcribed and analysed many of the participants had left either the District Health Authority or Trust and were not contactable. Merrell and Williams (1995) state that the researcher owns both data and product and it is they who have the responsibility to ensure that it is handled ethically. In this study tapes were only heard and transcribed by myself and then destroyed once analysis was completed. They raise the issue of product in terms of publication and whether this infringes the autonomy of participants. Following Merrell and Williams (1995) argument I felt that publication was my responsibility. However, use of the project results in terms of submission for a doctorate and potential publications was explained to all participants.

7.3 (e) Concluding comments on ethical issues

There are a number of ethical weaknesses for which this study could be criticised. Lack of scrutiny by an outside body was one of these. Secondly, the study could be criticised for placing pressure on CMHT members to participate in relation to group observations. Though space was left in the group briefing s for individuals to object it is likely that overall group pressure coupled with issues of power would play a part in suppressing objections.

As reported below (Section 7.5g), a number of participants avoided giving consent for interview. I took this avoidance as a refusal to participate at an individual level. However, they were present during observed meetings and therefore participated in the group research, though whether willingly is open to question.

7.4 Sample construction and units of analysis

A clear sampling strategy within qualitative case study underpins its ability to provide the fullest account of the social world. It is therefore important to give a full description of the sampling process (Kennedy, 1979).

There are two levels of sampling in qualitative case study – the 'case' and the sample within the 'case' (Merriam, 1998). Miles and Huberman (1994) call the latter 'within case sampling' and state that the researcher's sampling decisions in this context are predicated on two factors. The first is that sampling is almost always 'nested', that is it moves from a larger sampling unit to a smaller one or vice versa. Yin (1994) calls this 'embedded' case design in which 'the case' is analysed through a number of sub-units. Vaughan (1992) argues that patterns discerned through examination of small units of analysis can lead to analytical insight into the same phenomenon in larger units. The case may be seen therefore as a holistic analytical unit, rather than a 'sample' unit per se, with the whole being the sum of its parts.

The second factor to which Miles and Huberman (1994) draw attention is that sampling within qualitative case study is theoretically rather than *representatively* driven, particularly as this relates to a conceptual framework. One attempts to examine a *range* of features in the case. Even within this, one cannot hope to look at all the features of any one case, as this would be impracticable because of the large number of variables. Rather one looks at the significant features that may convey the overall picture.

The differentiation of sampling choice as it relates to generalisation between qualitative as opposed to quantitative case study is an examination of diversity or *range* of views rather than their prevalence (Richardson *et al.*, 2000). Purposeful sampling therefore is used is to display multiple realities rather than the most common (Lincoln and Guba, 1985).

Bergen and While (2000) examines case study sampling as it relates to units of analysis. They argue that units of analysis have a differentiated meaning. The first they term the

'sampling unit', that is the source of data; the second is the 'unit of enquiry', that is the dimensions or subjects for enquiry.

Bergen and While's (2000) taxonomy draws attention to the lack of clarity in Yin's (1994) notion of the embedded unit case design. However, their concentration on differentiation and disaggregation of sampling units may lead to a focus on the individual sub-unit at the expense of their inter-relationship, potentially undermining the defining feature of case study as a method – its holistic nature. Whilst Bergen and While's (2000) work on sampling appeared after the construction of the sample and collection of data for this study. Their work was important to this study for its iterative value; providing a confirmatory perspective on the essential elements of the study's sampling frame.

In this study a sampling approach was needed that ensured the conceptual model of 'The Case', its underpinning theory, the questions it attempts to address and the inter-relationship between sampling units and these elements was maintained to ensure overall case coherency. Sampling needed to be purposive in terms of theory and diversity so that both the theoretical and more contemporaneous policy issues could be addressed. In effect a range of observations was needed to facilitate comparison and exploration in depth and breadth that would extend beyond the case site.

Purposive sampling requires prior knowledge of the research population in relation to the subject of study. Prior to entering the field therefore, Onyett *et al.*'s (1994) survey of CMHT membership was used to provide an indicator of the range of professionals likely to be found in a CMHT. Following identification of the case site, this empirical work was supplemented by *a priori* knowledge of the Trust to inform the sample construction. To further facilitate this process the research questions and theoretical propositions were disaggregated into a set of dimensions upon which to focus in the data gathering process (Box 7.2). This provided an additional indicator of the data sources and units of analysis that were needed.

Issues for examination	**Theoretical Propositions**	**Dimensions of enquiry**	**Indicative Sample Unit**	**Actual Sampled Units**
Context: • What are the aims of policy? • Why are particular policies emphasised? • How is policy formulation and implementation communicated and to whom? • How is policy compliance monitored? • Which policies are identified as problematic and why?	• Policy is often an attempt to delimit risk. • Policy ambiguities are left for managers and practitioners at local level to negotiate	• Emphasised Priorities • Background to policy • To whom are messages addressed • Degree of specification/ guidance/ expectations • Criteria for successful implementation • Reporting expectations/ mechanisms • Enforcement mechanisms	• Professional Media • National and Local Policy Documents • Policy advisers/ formulators • Main Context Stakeholders – Commissioners of Mental Health Services	• Health Service Journal/ newspapers • Theoretical and empirical literature • Legislation, e.g. Mental Health Act (1995), and central guidance documents • Local contract and strategy documents • Interview with Mental Health Commissioners (2) • Interview with Chairman of GP Fund holders (1) • Interview with policy advisor (mental health nursing) (1)
Local Operational Management: • What are identified as priorities and how do these priorities impact on operational management? • Why are policies identified as problematic? • How are priorities communicated to CMHT s and stakeholders? • How is local compliance monitored and communicated to stakeholders and CMHT s? • What causes managers anxiety with regard policy and why?	• Policy ambiguities are left for managers and practitioners at local level to negotiate • Service organisations will often act in ways that appear contradictory to policy. • Individuals will experience conflict between their personal values/role conception and some of the priorities they are required to implement leading to a sense of alienation from policy and their employing organisation • Individuals, teams and organisations will focus on meeting explicit priorities at the expense of non-emphasised activities.	• Organisational structure of management and relationships • Emphasised policies • Reporting expectations/ mechanisms • Points of policy tension/ harmony • Communication mechanisms between operational management and context • Communication mechanisms between operational management and CMHT s	• Policy documents • Internal Management documents • Managers	• Local contract and strategy documents • Internal case site documents, e.g. policy guides, minutes of meetings • Interviewing individual managers within the case site (7) • 1 group interview with managers from other mental health trusts (4)

Box 7.2 Relationship of study to design and sampling

Issues for examination	**Theoretical Propositions**	**Dimensions of enquiry**	**Indicative Sample Unit**	**Actual Sampled Units**
CMHT s: • Of which policies are the CMHT conscious and why? • What are the priorities for the CMHT and why? • What does the CMHT communicate to management and why? • Are there are there differences of perception between the various professionals within the CMHT and why? • How and why do differences of perception affect relationships within the C. .M. H. T. and its operationalisation of policy? • **How and why does the CMHT influence the individual practitioner**	• Policy ambiguities are left for managers and practitioners at local level to negotiate • Individuals will experience conflict between their personal values/role conception and some of the priorities they are required to implement leading to a sense of alienation from policy and their employing organisation • Individuals, teams and organisations will focus on meeting explicit priorities at the expense of non-emphasised activities. • Practitioners and teams will develop routines and processes to deal with dilemmas set up by policy ambiguities and conflicts. • Individuals and teams will attempt to convey an image of responsiveness in order to deflect criticism arising out of resource constraints. • Individuals and teams will manipulate policy priorities by non-operation or utilising their boundary spanning positions to influence information about policy • The interaction between individuals within the team will shape team responses to policy	• Emphasised policies/ priorities • Formal and informal reporting mechanisms • Points of tension/ harmony between CMHT and operational management • Points of tension/ harmony between CMHT members • Formal and informal reporting mechanisms • Routines of CMHT • Influences of policy/ priorities on CMHT decisions	• Policy documents • Internal documents • Team Activities • CMHT members	• Policy/ internal documents • CMHT Referral Meetings • CMHT Business Meetings • Interviews with Practitioners (19) • 3 Group interviews with staff from other teams (16)

Box 7.2 Relationship of study to design and sampling

Issues for examination	Theoretical Propositions	Dimensions of enquiry	Indicative Sample Unit	Actual Sampled Units
Individual • What are the individual perceptions held of national policy and why? • Of which policies/guidelines/local requirements are individuals most conscious of/ internalise and why? • What tensions exist for the individual practitioner between different normative expectations (professional, organisational and personal) and why? • What do individuals include in their frame of reference when conceptualising their role and how does this affect their decisions/ actions and views of local and national policy?	A) Policy ambiguities are left for managers and practitioners at local level to negotiate B) Individuals will experience conflict between their personal values/role conception and some of the priorities they are required to implement leading to a sense of alienation from policy and their employing organisation C) Individuals, teams and organisations will focus on meeting explicit priorities at the expense of non-emphasised activities. D) Practitioners and teams will develop routines and processes to deal with dilemmas set up by policy ambiguities and conflicts. E) Individuals and teams will attempt to convey an image of responsiveness in order to deflect criticism arising out of resource constraints. F) Individuals and teams will manipulate policy priorities by non-operation or utilising their boundary spanning positions to influence information about policy G) Individuals will rationalise their perceptions through the use of heuristics that change in relation to the pressures to which they are subject	• Professional background • Views and understanding of policy (national and local) and rationale • Issues seen as problematic • Influences on decisions • Reporting mechanisms • Individual priorities	• Managers • Practitioners	• Interviewing individual managers within the case site (7) • 1 group interview with managers from other mental health trusts (4) • CMHT Business Meetings • Interviews with Practitioners (19) • 3 Group interviews with staff from other teams (16)

Box 7.2 Relationship of study to design and sampling

Whilst this strategy indicated the general groups to interview it did not identify the specific personnel within the case site. This was important for seeking out those most likely to provide the best perspective on the case issues and time management. An emergent open-ended interview strategy such as that suggested by Lincoln and Guba (1985), the informational *isomorph*[25], was not possible due to the time constraints previously discussed.

Two approaches were followed to determine who would be interviewed in the 'field'. The first was to identify participants who could best inform the research and the second was to access and observe a sufficient range of people, activity and documents to facilitate the construction of a picture of the 'The Case' rich enough to enable the research questions to be answered (Morse and Field, 1996).

In determining who would constitute the sample for interview two strategies were followed. The first was to utilise the conceptual framework and its relationship to the theoretical propositions and questions. This suggested operational managers of the community mental health service, key stakeholders within the context of the service, particularly those who commission services and lastly members of the CMHTs should be interviewed.[26]

Within this individual sampling frame however, there were two omissions that could be seen as weaknesses. The first is that the Trust general manager of Adult Services was not interviewed. This was because at the time of data collection this post was vacant and the Clinical Director of Adult Services (who was interviewed) was acting in this capacity. This compensated for by a group interview where one of the participants was a senior general manager.

The second weakness was that a manager from social services was not interviewed. This occurred because the manager of social workers who worked within CMHT A declined

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[25] This involves engaging in a serial sampling strategy based upon an ongoing analysis of material and construction of a working hypothesis, to the point of data saturation and redundancy (theoretical sampling).

[26] See Chapters 10 and 12 for a full discussion of the specific processes and features associated with accessing these groups and individuals.

to be interviewed and because there were no social workers integrated into CMHT B. Whilst this omission does not compromise the study's conclusion, interviewing at least one social services manager might have enhanced the range of views that was gathered.

It was decided not to observe the interface between the clinician and the client for a number of reasons. The first was that one would need to observe the activity of most members of each CMHT with their caseload over a sustained period for an effective and relevant policy analysis. The pragmatics of available time indicated that this was not possible. Second, most contact between key worker and user took place in intimate surroundings, usually the user's home. It was felt observation would be clinically intrusive in these circumstances, which could not be justified by what might be learnt in relation to the study objectives.

7.4 (a) Sampling documents

The emphasis on policy within the case indicated that documents would be an important source of data and therefore would need to be included within the sampling frame. Yin (1994) states that documents, amongst other things, provide an important inferential source, suggesting new lines of investigation within a case study. However, he also warns against over-reliance upon them since they are written for a particular audience and purpose other than that of the researcher. One therefore has to consider the purpose of document analysis within the study. Within this study the primary purpose of document collation and analysis was to provide information on contextual issues and to assist in assessing the influence of official documents (as artefacts of policy) on perceptions.

Decisions about which documents to review were informed by two strategies. The first was the conceptual framework, particularly as it related to context, external to the case site and translation of policy within the case site. Consideration of the context indicated a need to sample key legislative and guidance documents. It was also reasoned that one would need to consider Government and campaigning organisations' reports on community mental health services. At the meso level (the point at which there was likely to be an interface between the context and the case site) there was a need to

examine local strategy documents and contracts between commissioners and the community mental health service.

The second strategy was to ask key informants within the case site which 'internal' and 'contextual' documents they thought needed to be examined. This would also indicate which areas were seen as potential issues 'internally' and provide ready access to key material since such stakeholders were also the likely 'gatekeepers' to such documents (See Appendix D).

7.4 (b) Concluding comments on sampling

Sjoberg *et al.*, (1991) point out that there is confusion about what constitutes units of analysis within case study. They argue that they are individuals, structural patterns, and an interaction between macro and micro levels of analysis. Therefore to focus on individuals or the organisation alone will provide an incomplete analysis. The intersection of individuals with the organisations in which they operate is dialectical in nature and means that both have to be considered as units of analysis, "the whole, which has a reality somewhat apart from its individual members, nonetheless is dependent on human agents for its existence" (Sjoberg *et al.*, 1991, p.39).

The inter-connectedness between sample unit, unit of analysis and case were expressed through the development of a set of dimensions of enquiry that reflected the research questions and underpinning theoretical issues. Therefore an integrative 'framework' in the construction of the sample (Box 7.2 and 7.3) was developed in contrast to that proposed by Bergen and While (2000), whose model emphasises differentiation of sample. As such this integrative framework maintains the essential relationship between the 'individual and the whole' enabling a holistic as well as sub-unit analysis of the case.

The sampling strategy was a combination of a pre-determined set of concepts relating to who and what to observe, modified through consultation with participants/ stakeholders once in the case site setting. The main unit of enquiry in this study was 'the relationship between policy and actors within the community mental health service of the chosen

case study site'. The sub units of enquiry were located within the conceptual framework and theoretical propositions, consisting of group interpretation of policy, individual perception and the interface between the two. Contextual units of enquiry were individual perception of stakeholders and emphasised policies. The sample units were documents, CMHTs as groups, individual practitioners within each CMHT and managers, both as individuals and as a group (Trust and Commissioner).

7.5 Data collection

Within this study there were four general data points – documents, meetings, individuals and groups. Reflecting these four data points, four data collection techniques were employed, document collation, observation field notes, individual interview and group interview. This section outlines and discusses the design of the data collection instruments used to collect material from each of these domains.

7.5(a) Piloting within Case Study

Though Yin (1994) advocates the piloting of 'cases', Robson (1997) points out that piloting in case study can be problematic and sometimes not possible. This is because of the uniqueness of 'the case' in terms of site location, temporality or the knowledge of the researcher and that there is unlikely to be an equivalent for piloting purposes. It was decided not to pilot 'The Case' because of these issues and, in addition, because the intended instruments could be adjusted in response to the data obtained. However, it was decided to pilot the interview instrument for the purpose of practice (See Section 7.5d).

7.5(b) Documents

Yin (1994) emphasises the importance of documents in case study, whilst Silverman (1997) states that it is a feature of a modern society that a vast amount of written material is produced. This requires a reductive approach that focuses on documents of relevance. The written material focused upon in this study was officially produced documents that related to community mental health policy and internal policy documents to the case site. It was considered whether to examine case notes kept by practitioners. However, it was decided not to do this on three counts. Firstly, because

the emphasis within the case was on how policy is communicated to professionals and how they perceive policy through such communication their perceptions could be gauged adequately through interview. A focus on case notes would not necessarily enhance this.

Second, the Trust was moving to a computerised system of maintaining case notes utilising a standardised format. Therefore, how staff utilised such forms might be affected by using a word processor. For example, evidence of changes of phraseology and corrections would be removed through the delete function whilst this is not usually so in paper/ hand written records. Thirdly, the potential size and range of such material and the amount of time it would take to record it in relation to the time available to conduct the research project as a whole militated against its examination. However, it is acknowledged that this omission could be seen as a weakness in the data collection process.

Hodder (2000) notes that documents are material evidence of context and provide insight into the issues within 'the case. Atkinson and Coffey (1997) argue that documents do not exist as single entities but are invariably inter-related and refer to "other realities and domains" (p.55). Surprisingly, most research texts that deal with documents as evidence appear to focus on their analysis rather than on the practicalities of how one records/ catalogues their content prior to analysis. For example, Bassey (1999) deals with the issue of 'reading documents' in four-lines. Alternatively, Yin (1994) discusses their importance at length but fails to deal with how one goes about recording their content. This may be based on the view that documents are portable artefacts (Merriam, 1998), however this is not always the case.

An instrument was needed that would record each document's essential nature, the audience for whom it was intended, its relationship to other documents and the relationship of the document to the theoretical propositions and questions within the case study. A format outlined by Miles and Huberman (1994) for document recording was adopted. This emphasises the audience for whom it is written and how it might reflect theoretical issues and research questions (See Appendix E). This record proved

useful in relating the later analysis of documents one to another and providing the context data to assess the significance of other data – interviews and observations.

7.5(c) Observation and field notes

Gold (1958) identifies four roles the researcher may adopt to engage in direct observation – the *complete observer*, *observer as participant*, *participant as observer* and *complete observer*. The merits of each of these have been rehearsed in the literature over a number of years and will not be dealt with here[27]. For this study the role of 'complete observer' - that is being present at meetings but not participating – was chosen. This role was made clear to the CMHTs prior to entry into the field.

Maintaining and processing field notes can be problematic because they are constructed texts on the part of the researcher (Angrosino and de Pérez, 2000). Therefore there is a potential for bias. To minimise this problem it was decided to organise observational notes in three ways. Firstly, the role of 'complete observer' made it appropriate to take notes *in vivo* rather than after the events observed. To that end contemporaneous observations of meetings were recorded in a notebook.

SPACE – the physical setting

ACTORS- the details of people present

ACTIVITIES- the various contributions/ actions of the actors

OBJECTS – physical elements such as furniture

ACTS – specific actions

EVENTS – particular occasions

TIME - the sequence of events

GOALS – what actors attempt to achieve

FEELINGS -emotions in particular contexts

Box 7.3
Observational descriptive checklist
(Spradley, 1979)

Secondly, such notes focused primarily on a descriptive account using the Spradley (1979) observation checklist (Box 7.3). Lastly, interpretation related to the theoretical propositions was undertaken mostly immediately after the meeting ended through a

[27] See Robson (1997) for a review.

review of the descriptive notes, though occasionally contemporaneous notes were made on particular theoretical points if opportune.

7.5 (d) The research role once 'in the field'

The disturbance associated with the entry of an investigator into the field may be 'dampened' over time through the research participants' acceptance of the researcher's presence (Lincoln and Guba, 1985). In this study both CMHTs were initially curious about what was written down during their meetings and would comment on such. After a few weeks they got used to this activity and it no longer occasioned comment.

However, on entering the field to observe CMHT A maintaining the role of 'complete observer' proved nigh on impossible over time because of this very acceptance. This manifested itself in two ways. The first was occasional teasing about my research role. The second was to ask my opinion on clinical issues. Thus in becoming part of the context the group also identified me as part of their team.

Others have noted the difficulty for nurses when conducting research in health care settings to remain a 'complete observer' (Johnson 1997; White, 2000). The instances described raised the dilemma as to the degree to which affinity to the notion of 'complete observer' could be maintained whilst retaining the trust and confidence of participants. The immediate management of these situations was to respond positively to requests. Therefore, in effect the CMHT members determined investigator status, transforming it from one of 'complete observer' to 'participant observer', that is taking part in the activities that one is also observing.

This experience led to a review of the conceptualisation of the observational role when entering the field to observe CMHT B. It was decided not resist participation should the second team require this and to utilise such an opportunities as further insights into the CMHT's dilemmas. However, as indicated in Section 7.6(a) below, the relationship with this team, particularly in the initial stages of observations, was different to that with CMHT A. These experiences emphasised that the degree one is able to exercise autonomy in methodological decisions once 'in the field' is constrained by the sample

population and their decisions about the role of the researcher (Angrosino and de Pérez, 2000). Thus the reflexive nature of the research process as it relates to 'naturalistic observation' was revealed.

7.5(e) Individual interviews

Yin (1994) states that interviews are a significant source of evidence in case study since the approach deals with human affairs. Moser and Kalton (1971) state that the choice of what type of interview to conduct with a sample in qualitative research lies along a continuum of informality ranging from the completely *non-directive* interview to the *guided* or *focused* interview.

Robson (1997) believes the focused interview should be used to gather data from specific individuals involved in a particular situation following a situational analysis based upon observation and document analysis. It aims to gather data from individuals on the important aspects of a situation through the development of an interview 'topic guide'. These topics provide the initial focus for the interview and, depending upon the responses of the interviewee, are followed up by the interviewer through 'probing' statements further; thereby encouraging the respondents to expand upon their answers (Merriam, 1998).

Reflecting on the sample framework and these issues it became apparent that when interviewing individuals an instrument was needed that would allow retention of some control over the direction of the interview so that data pertinent to the research questions could be gathered. At the same time it would need to be sufficiently flexible to facilitate the emergence of views on issues. Therefore the *focused interview* was selected.

A topic guide relating to key issues for exploration was developed based upon the dimensions to be examined within 'The Case' (Witzel, 2000). These were based on the specific theoretical propositions and research questions as they related to the dimensions for exploration (See Appendix F).

7.5 (f) The function and employment of the interview topic guide

A topic guide within qualitative research incorporates an inductive-deductive construction (Witzel, 2000). It is deductive in that issues for exploration have been identified *ex-ante* through the consideration of previous literature, theory and situational observations. However, it is inductive in that the interviewer remains open to exploring a respondent's views during the conduct of the interview.

The initial issue with which all individual interviews started was a focus on the individual's role, "Can you tell me about your current role in mental health services". This was followed by specific exploration through use of 'probe' questions in relation to the respondent's answers and the theoretical propositions. Thus an inductive opening 'Can you tell me about your role' was employed followed by a deductive follow-up.

The interview guide was piloted with a colleague and a chief nurse advisor of a Trust that had been ruled out as a potential case site, in order to experience its administration. As a result of this exercise I became self-aware of a tendency to verbosity, which often necessitated the respondent to seek clarification of the question.

During the employment of the guide some adjustments were made in its administration. Drawing from the concepts of theoretical sampling, each interview was subjected to a preliminary 'listening' analysis to identify issues that might need follow up with another professional in a subsequent interview.

The professional/ organisational position of the respondents also suggested that certain issues needed to be followed up with some more than others. For example, the questions posed to the commissioners of mental health services focused more on issues of 'political' relations with the Trust management whilst those with practising clinicians focused more on 'professional' issues and internal relations with management. However, the essential components of the guide remained unchanged.

The interviews took place in each individual's office and were tape-recorded for the purpose of transcription. The length of interview varied, between 45 and 90 minutes, the

majority taking 50 minutes. The reason for this variation was to do with the willingness of individuals to talk.

Transcription did not take place until all interviews had been completed. This was a matter of pragmatics rather than methodological logic since there was insufficient time to transcribe them myself whilst data collecting. As such it could be seen as a weakness in terms of detecting nuances for follow-up in further interviews. However, each interview was thoroughly reviewed by listening twice to the recording and making notes for follow up.

7.5 (g) Issues of collaboration

Lincoln and Guba (1985) state that meaningful research is not possible without the co-operation of the respondents. On the face of it this seems self-evident. However collaboration is reliant upon the establishment of trust and familiarity between the investigator and the participants as the research progresses. Even when one establishes trust, the level to which it is given will vary from individual to individual. Thus within the two CMHTs, there were individuals who were more trusting and collaborative with the research than others.

All collaborated with the group observations, but some were reluctant to be interviewed on an individual basis, though none openly refused. However, two individuals avoided interview.

The degree to which this level of non-co-operation might affect an overall understanding of the 'The Case' was considered. This calculation was referenced to the holographic concept of the research situation (Lincoln and Guba, 1985), that is that the whole is the sum of its parts and each part is a sum of the whole. Thus what I found in any one part will be reflective of the whole. Therefore it was calculated that their non-collaboration would not compromise understanding. This judgement was based on the significance of the positions held by the individuals concerned, i.e. were their positions, characters etc., unique and important as evidenced by observations of the CMHT and were they likely to give information that could not be found elsewhere.

7.5 (h) Group interviews

In addition to individual interviews a series of group interviews were conducted following the completion of data collection with the two CMHTs. The purpose of these group interviews was two-fold. The first was to explore issues that needed further investigation. The second was to assess the degree to which observations and interpretations were reflected in the experience of respondents across the case site[28]. The quickest way to do this was to ask for volunteers to attend group interviews. Welch (1995).[29]

O'Donnell (1988) states the members of a group interview should have something in common. Groups were therefore organised as one for psychiatrists, one group for managers and two group interviews for professions allied to medicine working in CMHTs

There is a lack of agreement as to the optimum size for an interview group ranging from 6 – 12 (Byers and Wilcox, 1991; Stewart and Shamdasani, 1990). Though eight participants were invited to each group, actual group sizes varied from three (psychiatrists and managers) to five (one group of professions allied to medicine). Therefore, the nature of the group discussions became somewhat more intimate, which enhanced the level of discussion that took place.

An adapted topic guide was used to focus group discussion (Sink, 1991). These deliberations were tape recorded and transcribed.[30]

7.5 (i) Triangulation of data

The purpose of triangulation within a research study needs to be made clear since it impacts on the overall research design (Bergen and While, 2000). Multiple data collection methods are recommended for the purpose of triangulation to enhance data completeness (McDonnell *et al.,* 2001). One can use multiple data points to crosscheck or validate observations (Orum *et al.*1991), which was done in this study (fig. 7.1) to

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[28] Due to factors outlined in Chapter 10, the management group consisted of managers from other trusts.
[29] For a fuller description of the process See Chapter 10, Section 10.1b and Chapter 12, Section 12.1d
[30] For further discussion of the group interviews see Chapters 10 and 12

facilitate a contextual and holistic depiction of the reality of the case (McDonnell *et al.*, 2001).

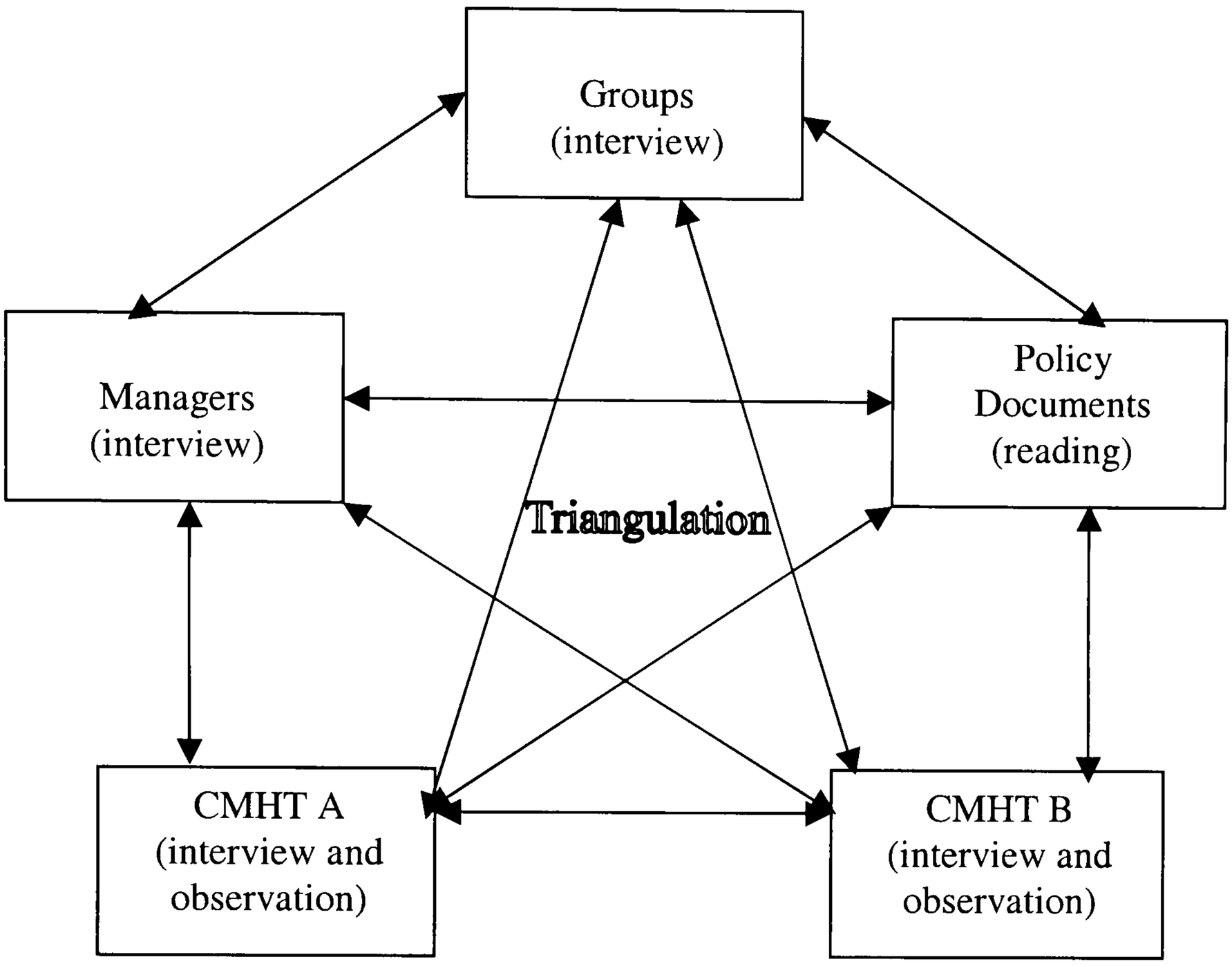

Figure 7.1
Triangulation of data sources

7.6 Issues of rigour

Merriam (1998) argues a potential weakness of case study is the over-exaggeration of a situation or over-simplification of the interaction of variables. This is because inductive proof cannot be conclusive, but only persuasive, as a number of theories may account for a given set of facts. Consequently, the researcher uses their judgement in relation to the level of collated facts that support a proposed theory. Use of judgement however, may mean that the subjectivity of the researcher in data gathering and analysis, leads to a selection bias where confirming data is emphasised and non-confirmatory data disregarded.

Lincoln and Guba (1985) suggest a number of strategies to guard against these pitfalls. This includes peer debriefing; triangulation (See section 7.5i above); prolonged 'field'

engagement and persistent observation; use of a reflexive journal and member checking (all of these with the exception of the last were utilised during this study).

7.6 (a) A consideration of reflexivity

The traditional view of the research account as an objective reportage of discovered social 'facts' has come under some criticism (See Hammersley and Atkinson, 1991 and Northway, 2000). For example, the convention of 'removing' oneself from the research account as a means of indicating and maintaining its objective nature is criticised as failing to acknowledge the role personal background and experience play in shaping the research process (Kleinman and Copp, 1993). Donmoyer (2000) believes that even the most basic acts of perception are influenced by individual *a priori* assumptions about the nature of the social world.

An example of the deep-seated nature of this 'objective' approach within research consciousness can be seen at work within the precepts of Grounded Theory (Glasser and Strauss, 1967). Glasser and Strauss (1967) argue that the researcher needs to approach the research area and data without any preconceptions of theory or hypothesis. Those who utilise grounded theory indicate that this is one of the significant problems in utilising the method (Hickey, 1997; Cutcliffe, 2000). Vaughan (1992) argues that such a 'removed' approach flies in the face of reality,

> "Even if we believe ourselves to be unfettered theoretically, we always begin a research project with an arsenal of preconceived theoretical notions accumulated from our own research, our reading of the work of others... in spite of ourselves" (p.195).

Thus one arrives 'in the field' with a set of conscious and unconscious paradigms that may influence what one *'chooses'* to see/recognise. Such personal paradigms need to be examined as an act of reflexivity, that is a reflection on 'processes, events, sensations, past experience and physical being' (Swift and West, 1998,p.2)

Hammersley and Atkinson (1991) state that the researcher needs to recognise the reflexive nature of the social research endeavour. Reflexivity in this context has two components - the interaction of the researcher with their choice of research subject and the interaction of the researcher with those who are the subject of that research

(Kleinman and Copp, 1993). The inter-personal responses that result from this interaction, what is termed *reactivity* may be a significant influence on the research process and its outcome (Patton, 1990). Sjoberg *et al.* (1991) point out that within social science the researcher's interaction with the research process needs to be considered as a variable. Thus Vaughan (1992) argues that the researcher explicitly needs to acknowledge their worldview in the research process and research account as a means of controlling for potential bias.

What Vaughan (1991) and others, such as Patton (1990) do not appear to consider in their discussions of reactivity is the practical/ practicable difficulties of dealing with reactivity. For example, one may be 'pulled' by one's professional background, should that be the same as those who are under observation, towards bias. This may be imperceptible since personal and professional values are can be enmeshed and operate at an unconscious level. It is therefore more difficult to be aware of and take account of such influences in order to deal with any bias that may result. This may be exacerbated by the degree of 'insight' into issues that the researcher thinks such a background can provide compared to the researcher without such a 'sympathetic' background with their subjects.

Disentangling 'insight' from bias can, therefore, be a difficult task. For example, during data collection with CMHT A, I identified with the team as a clinician. This gave an insight into their frustrations, because of similar experienced frustrations. However, it might have led to a bias in a selective/focused observation of those issues that I found frustrating. What made this more difficult to deal with was a personal reaction to one CMHT in terms of liking them combined with their desire to draw me into their debates. This phenomenon has been noted as occurring in other studies (Hammersley and Atkinson, 1991).

This was dealt with in a number of ways. One was through discussion with colleagues and experts (See Section 7.6c). The second was self-reflection and consciousness of separating observation from interpretation within note taking in the field. Finally, considering personal influences, if any, that may account for the phenomenon.

Hammersley and Gomm (1997) take a slightly different view to that of Vaughan (1992) on the purpose of reflexivity as a control for bias. They argue it should be seen as an opportunity for potential insights into how people react in or to situations. Certainly, this proved to be the case on occasion in this study, (See Box 7.4).

At this point myself and the medical student are asked to leave as the team want to discuss the suicides of a number of their patients. I ask whether I can return once they have finished this discussion. 'C2' looks at the rest of the team briefly and then agrees.

Thoughts on this incident: I feel awkward at this request as it feels as though the nature of my research has not been fully appreciated ('C2' has described it as seeing whether the team is meeting the purchaser's contract). It doesn't seem to have registered that I'm looking at the issues the team has to grapple with, manage and contain in order to meet all the policy demands placed upon them. Patient suicides would've been a perfect example of this. Therefore do they view me as a spy? Also why haven't I corrected 'C2's description of the project. ? Issue of my own socialisation as a nurse, or is it reflective of his power in the team?

Seems I'm not trusted. This I can understand as the team don't know me that well.

A second thought that occurs to me is that perhaps this may indicate a defensive mind set on the part of the team. They are discussing a number of suicides. Reminds me a little of the points made by OT1 about wanting to cover one's back; also Lipsky about areas not being open to management scrutiny.
Overall, however, a rather unexpected turn of events, compared to my previous experience [i.e. CMHT A]. *I hope over time the team comes to trust me and my discretion.*

Box 7.4
Entry in field notes demonstrating an example of reactivity and the value of reflection

It is important to understand how and what effect the researcher has on the research environment not just in terms of the local context of 'doing the research', but also as it relates to wider contexts (Hammersley and Atkinson, 1991). Thus one thought I had on a request to leave a team meeting was that the team saw me as a 'spy' who might inform on them to management on issues about which the team felt vulnerable.

Sjoberg *et al.*, (1991) state that the researcher needs to recognise that one's research and its results may reflect the researcher's position within a power structure or ideology that go beyond apparent objective interpretation. For example, part of the motivation for pursuit of this study is career orientated. According to Roman and Apple (1990) such considerations place limits upon the choices open to the researcher and thereby can affect their consciousness of the social world that they are investigating.

7.6 (b) Incorporating a conscious reflexivity into the research process

Patton (1990) states that the researcher needs to formulate a strategy prior to entering the field to deal with reactivity. The initial thoughts about this were cursory, because of personal familiarity with the research environment and some of the stakeholders. The intention was to 'play things by ear' and discuss issues as and if they arose with my research supervisor and colleagues. Miles and Huberman (1994), amongst others (Lincoln and Guba, 1985) suggest that one should keep a journal of one's research experiences and thoughts. Consequently one needs to consider a reflexive account in the reporting of a study.

Reflection is described as an *artistry of knowing* (Robson, 1997). Donald Schön (1991) argues that professionals, such as doctors, utilise tacit knowledge, which they have acquired through experience, to deal with uncertainty. Schön (1991) calls this 'knowing in action'. He argues that through becoming conscious of such processes and reflecting upon them a practitioner, "can criticise the tacit understandings ... and can make new sense of uncertainty or uniqueness which he may allow himself to experience." (Schön, 1991:74).

Schön (1991) suggests a number of areas that one may reflect upon of relevance to the research endeavour, including strategies and theories held about behaviour and feelings about a situation that led them to act in a particular way or the way they have constructed a problem, or the role which they have constructed for themselves in a particular situation. Schön's (1991) ideas, with which I was already familiar prior to this research, served to provide a focus around which I could formulate a strategy to deal with the issues of bias and insight consequent of reactivity.

According to Johnson *et al.* (2001) the reflexive critique needs to consider research techniques and procedures as an essential precondition in qualitative research to establish rigour. Thus a critical reflection on one's self and one's relationship to the research process acts as an essential element in maintaining its integrity and protecting the validity of the findings.

A number of writers, for example within nursing research, have suggested ways in which reflection can be incorporated into the research process and its procedures (Northway 2000), making the connection between conscious reflection on research and establishing an audit or methodological decision trail (Koch and Harrington, 1998). In particular the use of a reflective journal is seen as a verifiable and useful means of keeping a record of one's reflections on the research process, reactivity and methodological decisions (*ibid*). Yet as Northway (2000) points out such research accounts are still comparatively small. There is a recognition that incorporating reflexivity into the research account is difficult with a danger of becoming self-focused rather than focused on meanings ascribed by research participants (Fine *et al.*, 2000), elevating the individual experience of the researcher over that of the subjects of the research (Gergen and Gergen, 2000).

I've just read Kleinman and Copp's 'Emotions and Fieldwork'. This book's been a revelatory comfort! So many things that I immediately recognised – particularly in the area of researcher insecurity. I've got a couple of questions that I think I'll ask Alison (N.B. a colleague in the department at the time who suggested I read this book).

1) *Point on p.56 – 'letting go of immersion as the basis of our identity will make us think twice about separating data collection and analysis?' How do I square this with Ritchie and Spence's work?*

2) *Could she (Alison) be the person to read my field notes to?*

Box 7.5
An Example of a diary entry

I decided to keep a journal in which I would record my thoughts on the study as it progressed (See Box 7.5). This was relatively easy to maintain whilst I was engaged in the more passive elements of the project, for example reading preliminary literature. However, its regular maintenance became more difficult when I entered 'the field'. I found that the gap between field experience and writing that experience up was often wide. This was for a number of reasons, such as fitting data collection between work commitments and the responsibilities of family life once at home. Thus whilst 'writing up' the journal gave me time to reflect, it felt unsatisfactory because of a sense of 'divorce' between this activity and earlier events and thoughts. I did a number of things to correct this. For example, when taking observational notes writing down memos in a margin of my note book as thoughts occurred to me and taking five to ten minutes after an interview to write up a reflection on it (Box 7.6).

7.6 (c) Discussion with colleagues

Philips (1990) argues that the qualitative researcher needs to subject their views to the critical scrutiny of informed others, what he refers to as acceptance of the 'critical spirit'. Therefore, a regular dialogue with colleagues about the project was conducted. This proved helpful in terms of clarifying what research approach to take in the early stages of the project and, combined with written reflection understanding the dynamics involved.

DCE was 10 minutes late for the interview. However, it didn't take long for us to start. My overall impression was that this is a thoughtful and perceptive man who is certainly no 'bull in a china shop' manager. Very informed, informative and surprisingly honest in terms of what he told me. Is my surprise reflective of my own prejudices about managers in the health service?

The main impression that struck me about his replies were the numb r of tensions operating at the management/ purchaser interface that are unique to the 'Trust' – the first of these was the relationship between 'C/E Com' and C/E. 'Com' used to be C/E of 'the Trust' and C/E her deputy. A relationship described by DCE as 'paternalistic'. Appears this proximity of relationships and history is a cause of tension between DCE and C/ E. Very much reflects Com1's views as to difficulty this relationship causes.

The other significant general issues were the importance of GPs and retaining public confidence. I was surprised how positive DCE's views on GPs were since this does not appear to square with 'the Trus' written material, e.g. C/E's briefing papers (?needs to be looked at when I am with CMHTs).

Difficulty with commissioners seems to be their linear approach to communication. The other surprising thing was that DCE said the commissioners found it much harder to make service cuts than 'The Trust' - "we take a more hard nosed approach" Clear they are responding to financial pressures.

Another feature was that nurses did not play an explicit role in his conversation – is this reflective of their lack of 'voice'/ importance in formulating strategic plans?

Interview took far too long in par because DCE was so forthcoming as an informant. Must keep time within reasonable bounds, about one hour? Perhaps I should reduce the number of questions I ask on personal background. I'll see how this fares in next interview.

Overall I enjoyed this interview. Respondents gave positive feedback about flow, though towards the end it all became a bit truncated because DCE had another appointment.

Box 7.6
An example of a reflection on an interview

In addition to these individual discussions, following completion of the observational and individual data collection and its preliminary review preliminary thoughts about the significance of the data was discussed with three recognised experts on CMHTs and community mental health practice (See Appendix G). This too proved helpful for clarifying thoughts about some of the issues that would need exploration within the group interviews.

7.6 (d) Concluding comments on reflexivity, ownership and rigour

Absolute objectivity is not a realistic goal, however balance and fairness can be achieved by guarding against over-selectivity through presenting material in relation to the research process, alerting the reader to personal biases and an emphasis on the 'ownership' of the research. The degree of trustworthiness, credibility and transferability (Miles and Huberman, 1994), that is the degree that findings within this study are internally consistent and have a relevance to similar settings, gauged through 'typicality'[31] of the case and the use of data triangulation serve to encourage balance and fairness in data collection and appraisal.

7.7 Issues in the choice of a procedural strategy for the analysis of data

An appropriate procedural approach in terms of data analysis needed to be selected. Grounded Theory (Glasser and Strauss, 1967) was considered since it focuses upon the generation of explanation from the account of 'insiders' and emphasises the 'emergence' of theory from data generated through constant comparison. However, there were a number of factors that suggested that 'pure' grounded theory would not be possible to use nor suit my purpose.

Grounded theory places great store on the inquirer approaching the field without pre-conceived ideas. The concept of 'The Case' in this study, having arisen from a combination of *a priori* knowledge, literature and theory, thus precluded its employment.

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[31] Transferability and credibility of this study are discussed further in Chapter 14, Section 14.2.

Secondly, Grounded Theory emphasises that one decides through constant comparison of the data who or what one should observe next to the point of saturation. Though this can be used in case study (Yin, 1994) in this particular study it was not possible because of limited time. Nevertheless the concept of a constant comparative analysis seemed an approach that could generate ideas during initial analysis; it was therefore partially incorporated in the process of data collection and initial review.

However, such an approach can be frowned upon. Maggs-Rapport (2001) recently argued that it is essential that researchers firmly ground themselves within one approach if their research is to have validity. However, there is an alternative view. Johnson *et al.* (2001) argue for what they term 'British pluralism'. They (2001) state that absolute conformity to a given research procedure does not necessarily guarantee rigour, but rather a sense of procedural security and rigidity in the research process. They argue that within qualitative research universal agreement as to what constitutes a particular philosophical approach, for example phenomenology, can be lacking. They state that the reality of the research endeavour in the field, dealing as it does with the realities of everyday life, often means that the researcher has to take a pragmatic as opposed to a 'pure' view in terms of methodological approach. The essential condition for rigour, they believe, is not methodological purity, but rather the reasoned rationale for combining methods as it appeals to "acceptable understandings of validity, honesty, avoidance of deception and the provision of relevant evidence" (p.248).

Taking the issue of methodological conformity as a measure of the validity of research and the counterview that fidelity to the phenomenon under study should inform research methods decisions, it is the latter view that was followed. In this case study pragmatics and purpose combined to indicate the adoption of an approach, derived from Grounded Theory, to guide data analysis that allowed for some comparative analysis and yet provided an analytical 'boundary'– Frameworks Analysis (Ritchie and Spencer, 1994).

7.8 Utilising Frameworks Analysis

'Frameworks' Analysis is seen as an approach conducive with case study methodology (Ritchie and Spencer, 1994) and is widely used in the examination of policy

implementation. One of the first Government studies on CPA implementation utilised the 'Frameworks Approach' (North *et al.*, 1993). The approach focuses on the development of matrices that facilitate 'within case' analysis through the development of 'indexing charts' ('Frameworks'). These Frameworks are developed through combining pre-established points of interest (generated from the research questions, theoretical concepts and propositions) and an examination of a sample of the data.[32] Once the preliminary Frameworks are established they are applied to all the data and further refined. This is done through a process of abstraction, in which data is summarised rather than represented verbatim within each 'Framework' (See Appendix H). The 'Framework description' of the data is then examined to develop a conceptual analysis. Verbatim data is used to illustrate both the Framework descriptions and the resultant conceptual analysis.

As discussed in Section 7.4(b) the focus of analysis was relational between individual and group perception of policy. This taken within the context of the conceptual framework[33] suggested the analysis of data in four ways. Firstly, to analyse individual responses in relation to professional backgrounds; secondly, between 'cases', through groups (that is managers and each CMHT); thirdly, to engage in cross case analysis and relate this back to the conceptual whole. Finally, holistically, that is to review the data overall in relation to the national context. Frameworks Analysis appeared to provide an effective medium through which to organise such an examination. I therefore attended a five-day training programme provided by the National Centre for Social Research in Frameworks Analysis to establish a basic competency in its application.

7.8 (a) Consideration of analysis tools

One of the issues considered before embarking upon analysis was whether it would be done manually (i.e. using paper and pencil), through a computer assisted qualitative data analysis (CAQDAS) such as that used by the National Centre for Social Research[34]

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[32] Thus for example a pre-generated Framework was 'Policy Cognisance' because it was obvious that there was a need for a Framework to identify which policies respondents were aware of, why and their opinions of these policies.

[33] See Chapter 6, fig. 6.1

[34] This was an issue because the NSCR was the organisation which invented Frameworks Analysis and they used MS-Excel spreadsheets.

(using a MS Excel spreadsheet) or an alternative established computer assisted analytical package. This is an important decision since the use of CAQDAS remains a somewhat contentious issue within qualitative research, particularly whether or not it distances the researcher from their data (Bong, 2002; Roberts and Wilson, 2002) and thereby impedes or distorts analysis (Bourdon, 2002).

When thinking about the processes involved in Frameworks Analysis in relation to the context of the study's purposes it seemed that much of the coding of data would involve what Richards and Richards (1993) refer to as 'data theory boot-strapping', that is an examination of data using prior theory to construct an explanation of the relationship of evidence from the bottom-up, each explanatory fragment leading to the next. This suggested a laborious and time-consuming process, in which data analysis would become a time consuming clerical task. Abstraction would also require that data be retrieved through the Framework codes generated. Using a computer in this process seemed therefore logical in terms of time saved and flexibility compared to manual methods.

Using a spreadsheet to analyse data was considered. Certainly this has the advantage of neatly fitting into the standard concept of 'Framework', with the accumulated cells in effect providing a ready-made matrix. However, this seemed somewhat time consuming compared to the degree of flexibility it offered in terms of data retrieval. The potential offered by other packages, for example QSR Nudist 4, which requires minimal preparation of word-processed data and speedy access suggested this was the package to use in terms of data management during analysis. The package also has a matrix generation function. The package was also chosen because it is so well established within the field of qualitative research and I had some familiarity with it, thereby reducing the amount of time needed for familiarisation with its operation.

7.8 (a: i) Some disadvantages in using QSR Nudist v4

In terms of data exploration the package's primary utility was data storage and retrieval in relation to Framework themes. However, when the package was used in the analysis some disadvantages appeared. Principally the package (based as it is on the concept of

tree building) did not allow one to view the overall relationships of coding very easily, but only 'branch' relationships. As such it somewhat impeded overall conceptual thinking, though it facilitated thinking at the specific level.

7.8 (b) Process of analysis

Robson (1997) points out that the more conceptually definite a case study design is, for example guidance by a conceptual framework, the more potential for misinterpretation of data. He states that there is no obvious solution to this dilemma. As indicated in Section 7.8(a) Frameworks Analysis, suggests that one incorporate the conceptual framework within the analysis (Ritchie and Spencer, 1994). This was done.

All transcript data was prepared for entry into the QSR Nudist v4 package. This was done by reading transcripts and breaking up sections with separators and line codes. This exercise had the added advantage of enhancing the overall familiarity with the data. Following this external documents (official reports, memos and so on) were line coded ready for entry using the 'import external documents' function and notes outlined in section 7.5 (b) were attached using the 'memo' function.

The schema as laid out in figure 7.2 was followed. Separate files in QSR Nudist were established for Managers and CMHTs. Within each file separate sub-cases were established to distinguish between Commissioning Managers (including the GP Fundholder representative) and Trust Managers; CMHT A and CMHT B. Within each of these individuals were identified as sub-units; as were the group interviews, field notes (divided between business meetings, referral meetings and care review meetings) and documents. The purpose of this was to assist identification of material by individual and group and to facilitate cross case analysis.

Document analysis was based upon a sight-reading of all printed material relating to Commissioning and Trust operations utilising the document analysis form (Appendix E) suggested by Miles and Huberman (1994) and the line coding noted above. Interview transcripts were also read in this way and memos written with a view to the development of chart content. The purpose of this exercise was three-fold - to enhance

familiarisation with the material; to assist in the construction of a 'thick' descriptive analysis of the case context (See Chapters 8 and 9) and to identify recurrent themes that would need to be explored.

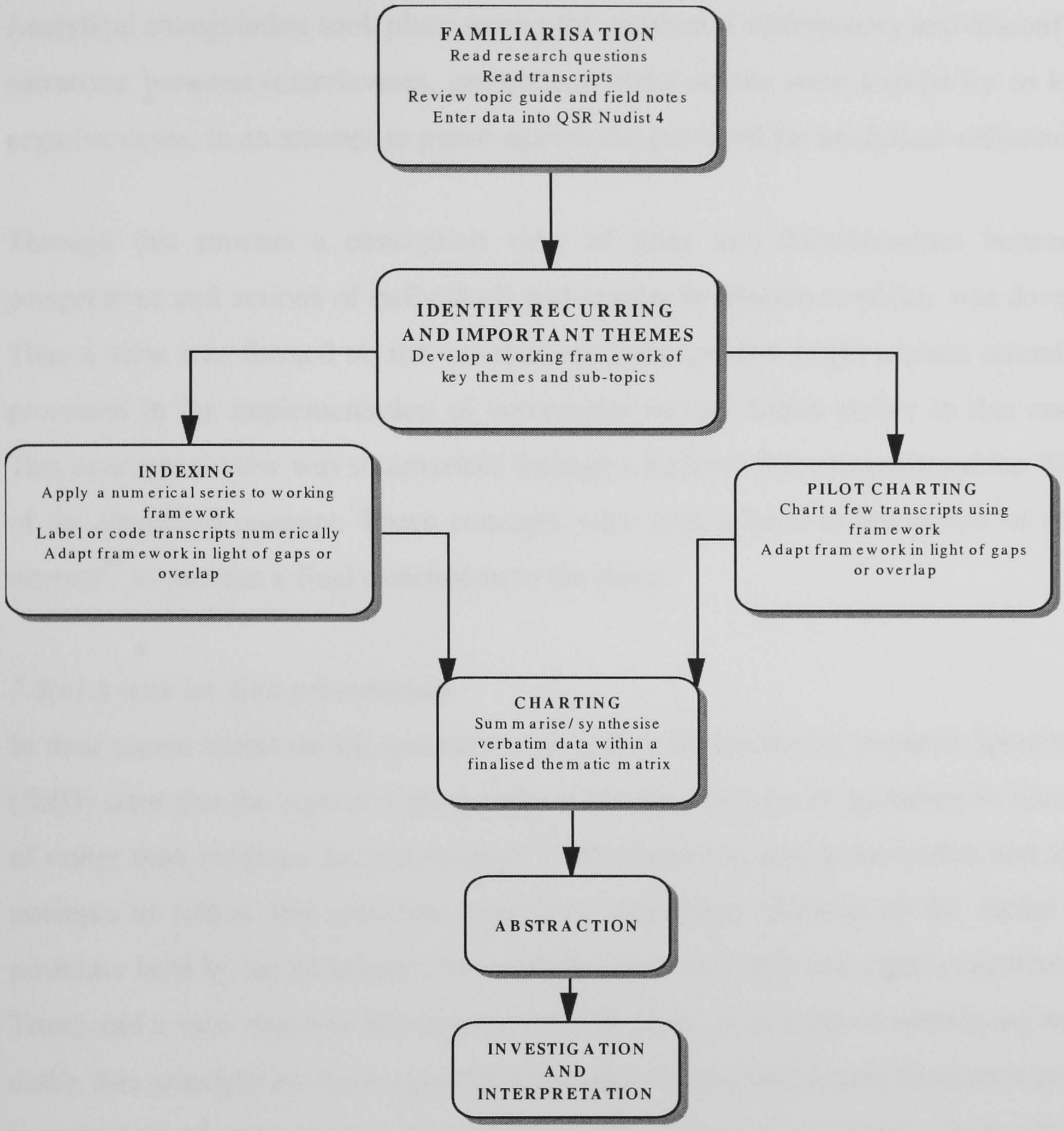

Figure 7.2
Stages of the analysis process

Following the familiarisation stage transcripts were re-read with their attached memos. At this stage patterns in the data were identified using QSR Nudist's tree building facility to either refine the pre-established Framework Charts or develop new ones, with each central theme (and its sub-units) then further grouped under a Framework heading to provide the basis of a 'working' chart. Two sets of charts were developed – one for

managers and one for CMHTs. These were then applied to three interviews from managers and three team members from each of CMHT A and CMHT B (a form of piloting) to further refine the charts. Once this was done all material was subjected to chart analysis, abstracted and summarised (See Appendix H).

Analytical triangulation took place during this process. Confirmatory and disconfirming narratives between interviewees, groups and observations were looked for to identify negative cases, in an attempt to guard against the potential for analytical reification.

Through this process a conceptual view of links and discontinuities between the perspectives and actions of individuals and groups in relation to policy was developed. Thus a view was formed on the variable relationships that might explain attitudes and processes in the implementation of community mental health policy in this case site. This conceptual view was summarised through a heading that encapsulated the 'flavour' of the identified concept. These concepts were then related to the points of research interest[35] to provide a final conclusion to the study.

7.8(c) A note on data presentation

In their recent report on the assessment of quality in qualitative research Spencer *et al.* (2003) state that the sign of a good study is the presentation of quotation as *illustrative* of rather than *evidence* for conclusions[36]. The following data presentation and analysis attempts to follow this principle; however, sometimes, because of the nature of the positions held by an informant (for example there was only one chief executive of the Trust) and a view that was felt important to represent or in terms of identifying negative cases, this principle has been sacrificed. Departure from the general illustrative principle is indicated when it occurs. To emphasise the illustrative principle most quotes are presented separate from the text.

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[35] See Chapter 5, Section 5.4 and Box 5.3

[36] I was already familiar with this argument as I had attended a training workshop run by Jane Ritchie on this subject.

7.9 Conclusion

Kemmis (1980) states that the case study researcher needs to make a case for the conclusions about their 'case'. Part of demonstrating the case for one's conclusions is to explain the process that led to them. This Chapter outlined the process followed in investigating the case. The results of this process are presented in the following chapters.

PART III

DATA, ANALYSIS AND DISCUSSION

CHAPTER EIGHT

A Description and Situational Analysis of the Local Case Context: The District, Resource Pressures and Commissioning

8.0 Introduction

In the 1950s the French psychoanalyst Lacan pointed out that the particular meaning that individuals ascribe to objects and events is determined by the context in which they are perceived (Lacan, 1977, *cited in* Wheatcroft, 2003). Rochefort (1988) states, "the approach of mental health providers in a given era cannot be understood apart from an appreciation of the types of problems they immediately faced" (Rochefort, 1988:148). The purpose of this Chapter therefore is to describe the local context in which managers and CMHTs operated in the 12 months prior to data collection.

Several documentary sources were used (See Box 8.1 below). A range of further documents including internal minutes of meetings, financial reports and letters were also examined to provide depth of understanding to the strategic and operational documents.

However, much of this supplementary material was fragmented and incomplete as it was supplied by individuals within the District Health Authority and the Trust, rather than obtained from one central source. Therefore data abstracted from the descriptive frameworks generated from interviews conducted with the local Health Authority commissioners, senior members of the Trust management board and the GP fund holders' representative were examined and used to supplement these sources.

Section 8.1 presents a profile of the District in terms of population and organisational structure as it affected mental health services, with particular reference to long-term users living in the community. Section 8.2 presents a synopsis and analysis of the local

joint strategic plan. Section 8.3 describes and assesses the significance of the resource pressures that operated on District mental health commissioning during 1996/1997.

CONTEXTUAL

Case Site Context Documents

- The 1991 Office of Population and Census Study (the most up to date available at the time of data colelction);
- The King's Fund Reports on healthcare in London produced in 1997 (Johnson *et al.*, 1997; Boyle and Hamblin, 1997; Harrison, 1997);

OPERATIONAL

Local Strategic Documents

- The 7 year strategic plan for mental health formulated at the end of 1993 by the local Health Authority, FHSA and LA councils;
- The local community care plans for 1996-97 from two of the borough councils, which played host to the case sites;

Health District/Trust Operational Documents

- The contract drawn up between the Trust and the District;
- Core quality standards

Internal Trust Documents

- Business Plans for 1996/ 1997
- The annually published Long-Term Case Register Report produced by the case site the Trust;
- An attitude and image survey conducted for the Trust by independent consultants.

Supplementary Local Documents

- Internal minutes
- Letters
- Annual Trust financial reports

Box 8.1

Categories of documentary sources

Section 8.4 outlines the commissioning arrangements that were in place within the District and for GP fund holders. This is followed in section 8.5 with a description of the processes involved in contracting between purchasers and the Trust and how contract performance was monitored.

8.1 The configuration of the case District

In 1997, the case site District Health Authority (hereafter the District) was in the upper quarter of London health districts in terms of population size. The District was in the top 50% of the 16 London health authorities in terms of black population and in the top 25% in terms of Asian population. It covered three local borough council boundaries (hereafter LAs 1, 2 and 3) and was served by three NHS mental health trusts - the case site, (hereafter the Trust) covered the boundaries of two local councils, one outer (LA

2) and one inner city borough (LA 1)[37]. The two other trusts covered a third of LA 1, and one outer borough (LA 3) respectively.

8.1(a) Prevalence of mental illness

The prevalence of mental illness in the District was located at the upper end of the spectrum. Measured against the psychiatric needs index (See Box 8.1) the District had, in 1997, a psychiatric needs score of less than 100. However, this overall moderate score belied the fact that the score for some neighbourhoods in LA 1 was amongst the highest in London.

- Standardised Mortality Ratio (SMR) aged 0-74
- Proportion of population in households headed by a lone parent
- Proportion of dependents with no carer
- Proportion of those of pensionable age living alone
- Proportion of population born in the New Commonwealth
- Proportion of adult population who are permanently at risk

Box 8.2
The Psychiatric Needs Index
(Source: Boyle and Hamblin, 1997)

Such concentrations had service and resource implications, with the 1993 joint strategic plan (See section 8.2) utilising the issues of concentrated deprivation as part of its rationale for developing a more geographically targeted mental health service in which resources would reflect need. The Plan drew attention to the particular problems the District had in relation to the general funding allocation formula (See Chapter 2, Section 2.2) utilised by the Government,

> "The District is concerned that the regional and national capitation methodology fail to take proper account of the differences in health needs between District Health Authorities, and the significant factors affecting mental health expenditure."

In addition to concentrated areas of deprivation and a high concentration of ethnic minorities, the District had one of the highest psychiatric hospitalisation rates in London, standing at 140, which, as reports such as those issued by the Monitoring Inner

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[37] The focus of this chapter will be on LA1 and LA2, as it was these areas that were served by the two CMHTs (CMHT A and CMHT B).

London Mental Illness Survey Group (Audini *et al.*, 1995) made clear placed pressure on resources.

8.1(b) Nature of the long-term user population living in the community

'The Long Term Case Register', established in 1990 by the Trust, provided an annual demographic, clinical and service usage profile of long-term service users at a particular point in time – April of each year (See Table 8.1 and 8.2). It enabled a tracking of the profile of the long-term user population over time. Published towards the end of each calendar year, it focused on users who were over 16 years on April 1st, had had their first contact with the Trust's psychiatric services at least two years prior to the survey and who had remained in contact. These individuals were primarily under the care of the CMHTs.

Demographic		**Ethnicity**		**Primary Diagnosis**	
Average Age -	47.3	UK/Irish	65.4%	Schizophrenia	57.0%
Female -	50.5%	Afro-Caribbean1	5.5%	Manic-depression	12.8%
Male	49.5%	Asian	8.0%	Depression	13.0%
Single	78.9%	African	4.1%	Anxiety disorder	4.3%

Table 8.1
Profile of individuals on the long-term case register (April 1996)

On the 1st April 1996 there were 1634 long-term users in the care of the Trust, that is 35.5% of the Trust's patients were classified as "long-term". The largest diagnostic group dealt with by the Trust were individuals with a primary diagnosis of schizophrenia.

In addition to providing an overall profile of long-term users under the care of the Trust, the long-term case register also identified the degree to which CMHTs adhered to the requirements of the CPA for this group. As such it was the principle audit exercise in terms of CPA policy implementation by CMHTs in the Trust.

8.1(c) Care arrangements for long-term users

Almost all users had a named key worker (98.5% in LA1 and 96.5% in LA2). CMHNs formed the largest number of key workers (Table 8.2). Whilst this allocation of key workers to users compared favourably with many trusts elsewhere (North *et al.*, 1993) it

nevertheless was not in full compliance with Government policy, which insisted that all users should have a key worker. In addition, this data only covered long-term users.

	LA1	**LA2**
Named Keyorker (KW)	98.5%	96.5%
Social Worker (KW)	10%	1%
CMHN (KW)	39.8%	50%
Psychiatrists (KW)	23%	23%
Occupational Therapists (KW)	1.7%	5.2%
Psychologists	1.9%	7.2%
Contact with at least two professionals	75.8%	69.8%
Contact with at least three professionals	45.7%	35.6%
Written Care Plan	94.8%	84.4%
Contact with:		
Psychiatrist	83%	80%
CMHN	47%	55%
Social Worker	32%	21%

Table 8.2
Professionals' contacts with users

LA2 had a significant proportion of users, more than 15%, without a care plan. Bearing in mind the import placed by numerous enquiry reports (Reith, 1998), on maintaining a written record of the care delivered this significant number of users without a care plan may indicate staff disaffection with information gathering or alternatively indicate the lower priority they placed on maintaining a written record compared to other elements of their work. However, one would expect such explanations to account for a general phenomenon across both local authority areas, the fact that this discrepancy was primarily confined to LA2 may indicate other differentiating factors.

CMHN input into care of users in LA1 and LA2 remained relatively stable with between 40% to 47%, and 47% to 55% of users receiving this input respectively. Over the period from 1990 to 1996 the proportion of long-term users receiving social work input in LA1 rose from 23% to 32%. However, in LA2 over the same period the rise

was considerably less marked (17% to 21%). This may be due to the fact that whilst social workers from LA1 were fully integrated into the CMHTs, those from LA2 were not and integrative working arrangements were still in the process of negotiation at the time of data collection.[38]

8.2 The local 'Joint Strategy Plan for Meeting the Needs of Mentally Ill People'

The 'Joint Strategy Plan for Meeting the Needs of Mentally Ill People', published in 1993, was a collaborative document drawn up between the District, the Borough Council of LA 1 and the local Family Health Service Authority (FHSA).

The document's stated purpose was to outline an agreed strategy between these three bodies to determine the format and delivery of community mental health services for the coming five years. It reflected a government policy orientation. For example, it emphasized that services needed to focus on SMI (Box 8.3).

Health Gain Criteria	**Monitoring**
1.Reducing number of long-term in-patients; 2.Increasing the proportion of severely mentally ill people who have something of value to do and their community tenure; 3.Implementation of a single jointly managed child mental health unit; data set 4.Reducing the proportion of people who relapse after detoxification from drug or alcohol consumption; 5.Increasing the proportion of severely mentally ill people who are retained in contact with the service; 6. Reducing the incidence of deaths attributed to self-harm; 7.Reducing the age standardised mortality rates for people with severe mental illness.	1.Contracting information; 2.Assessment and care management information; 3.Mortality data 4.Case registers 5.Public health common

Box 8.3
Criterion for assessing strategic progress

The strategy from the opening page indicated that it was to be resource led, its purpose being to review "needs, priorities, and resource utilization". In this context the strategic plan envisaged cutting services, for example the number of day hospital places, in order

[38] A particular point of difficulty was a reluctance on the part of LA2 to implement a joint recording system.

to pay for future developments in the CMHT service, rather than seek extra funding from central government.

An important feature of the strategy document was its emphasis on consultation and the language of user choice and empowerment, staff innovation and public education. However, the strategy made clear that the resource implications of empowerment and choice would need to be managed by the Trust and clinicians through the provision of advice to users and carers that took account of these implications,

> "Choices and *realistic* options need to be provided and explained in a way that enables informed decisions ...to develop successful management and coping strategies and *recognizing the constraints of their circumstances*". (my italics)

Thus the plan established the principle that individuals were not entitled to determine the services that they wished to receive. Further on in the document however, when delineating principles of individual care it stated that,

> "users should be aware that they are being valued as a person whatever their circumstances and by building on their strengths and expressed needs".

There thus were established potential contention between users, clinicians and the commissioning authorities by raising expectations but emphasizing limits.

The strategy was quite clear that the focus of CMHT practice was to be SMI and various strategic plans were outlined to reinforce and promote the development of this service delivery model. Thus, the document outlined plans to encourage GPs and CMHTs to develop close liaison relationships whilst also developing with GPs referral guidelines so that only those with SMI would be referred to CMHTs (as we shall see this was a source of contention between the GPs, the District, the Trust and CMHTs).

8.3 The resource pressures at the time of data collection

At the time of data collection a number of health authorities and local councils were cutting services in order to meet Government requirements to stay within allocated budgets (Butler, 1996b). One commissioner described the financial position of the case District as, "dire". As a consequence the commissioners emphasised "value for money"

in the contract price for services delivered. From January to March 1997 the District mental health commissioners instituted an examination of expenditure by local authority area, client group, utilisation of services and projections of need, with an emphasis on identifying savings.

The Trust had a number of nationally recognised specialist units. Local referrals to these units appeared to be increasing, especially in the areas of eating disorders, cognitive-behavioural therapy and personality disorders. These specialist Trust services offered a local, regional and national service, leading to unclear boundaries for contracting responsibilities and their relationship to other local services.

In an attempt to reduce costs in this area the mental health commissioners restricted the number of referrals non-fund holding GPs and others such as CMHTs could make to these units and, for the first time, insisted on introducing a waiting list for non-urgent referrals. Urgent referrals by-passed this, with urgency largely determined through consultation between the referring agent and the clinical specialist. Thus clinicians still retained a decisive voice in terms of "gate keeping". However, if one takes Friedson's (1970) concept of professional autonomy as sustained by the dominance of expertise then this innovation could be seen as a threat to the medical claim to determine the content of their work through directly constraining clinical decision making with regard which patients could be seen and when.

A regular theme in a number of the consultative documents issued by the commissioners during 1996 were the level of ECRs, which one described at interview as "spiralling out of control". The commissioners' financial review included comparative costing of services provided by each of the three trusts. The focus on ECRs tended to favour the Trust because its larger size meant it had a range of services and capacity to cope with patient demand. The result according to one of the commissioning managers was that with the two smaller trusts "our relationship is deteriorating as evidenced by several difficult contracts meetings lately".

The level of mentally disordered offenders (known as MDOs) to be found in LA 1 was also problematic in relation to in-patient costs. This was in part because the Trust had both medium and minimum secure units. However, since these individuals' cases were highly complex and politically sensitive (McFadyen, 1999) local authorities and services were reluctant to take them after discharge. This meant that there was a strain between demand, throughput and community provision.

8.3(a) Closure of services

As figure 8.1 shows, the commissioners' response to their financial difficulties was to engage in a general consideration of services with reference to comparative cost-effectiveness. With this as their reference point their approach was two-fold. First, at a service development level mental health services faced a degree of retrenchment in which closure and re-configuration of service would be approached cautiously. Hence, in-patient closures were frozen but day hospital closure continued[39].

In February 1997, the commissioners issued a consultation document to various stakeholders seeking views about the closure of the main day hospital. To reinforce the justification for closure the commissioners cited the support of the Trust management for the proposal. It was closed in early 1997.One of the more interesting aspects to this closure was that it had originally been envisaged within the Joint Strategy document. Yet this had not been presented as part of the justification.

Second, levels of discretion, particularly in relation to specialist services, were restricted through providing limited resources to fund referrals and vigorously emphasising priority groups for treatment, particularly SMI. The burden for overseeing these restrictions fell on CMHTs, which, in effect became the gate-keeper to other services. All this was achieved through the commissioning and contracting processes.

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[39] The moratorium on further in-patient closures was explained to me by one of the DHA commissioners as the result of an analysis that further closures were undesirable within the context of local service delivery at this time. However, since community developments had been predicated on the assumed savings that such closures would generate there may also be a further explanation than just the local context - that is that in 1996 the Secretary of State for Health, Stephen Dorrell, had emphasised a need to retain 24 hour care facilities (House Select Committee on Health 2000)

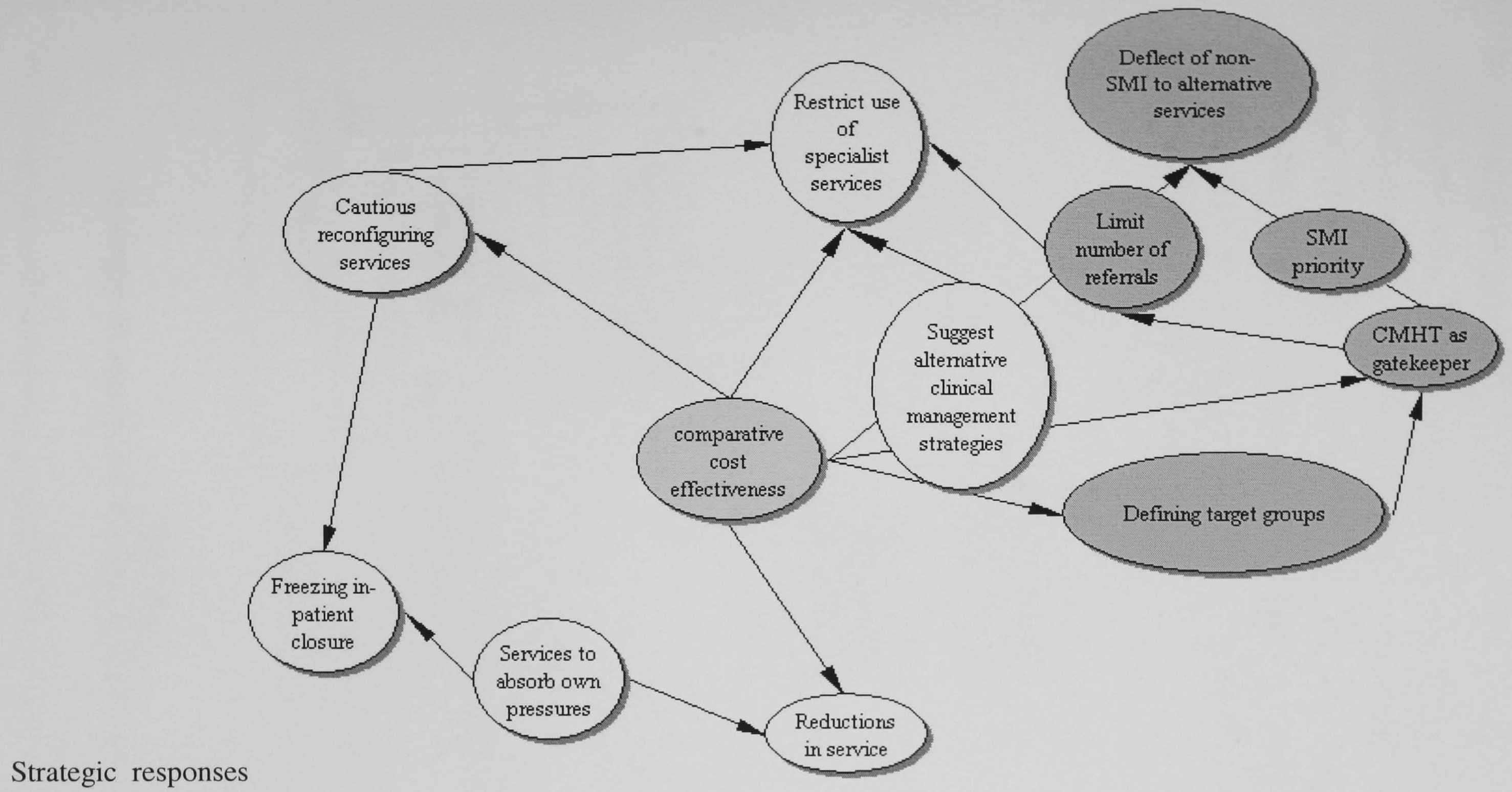

Figure 8.1 Commissioner responses to resource difficulties

8.4 Configuration of commissioning

The District commissioned health services from a range of providers, though the bulk of mental health services were provided by the Trust. Mental health services in LAs 1 and 2 accounted for 15% of the total expenditure on health by the District commissioners. Commissioning within the District was in the process of reorganisation from a system based on District wide commissioning to one based on localities[40], of which there were four. The exception to these arrangements was mental health, where commissioning remained District wide (See figure 8.2).

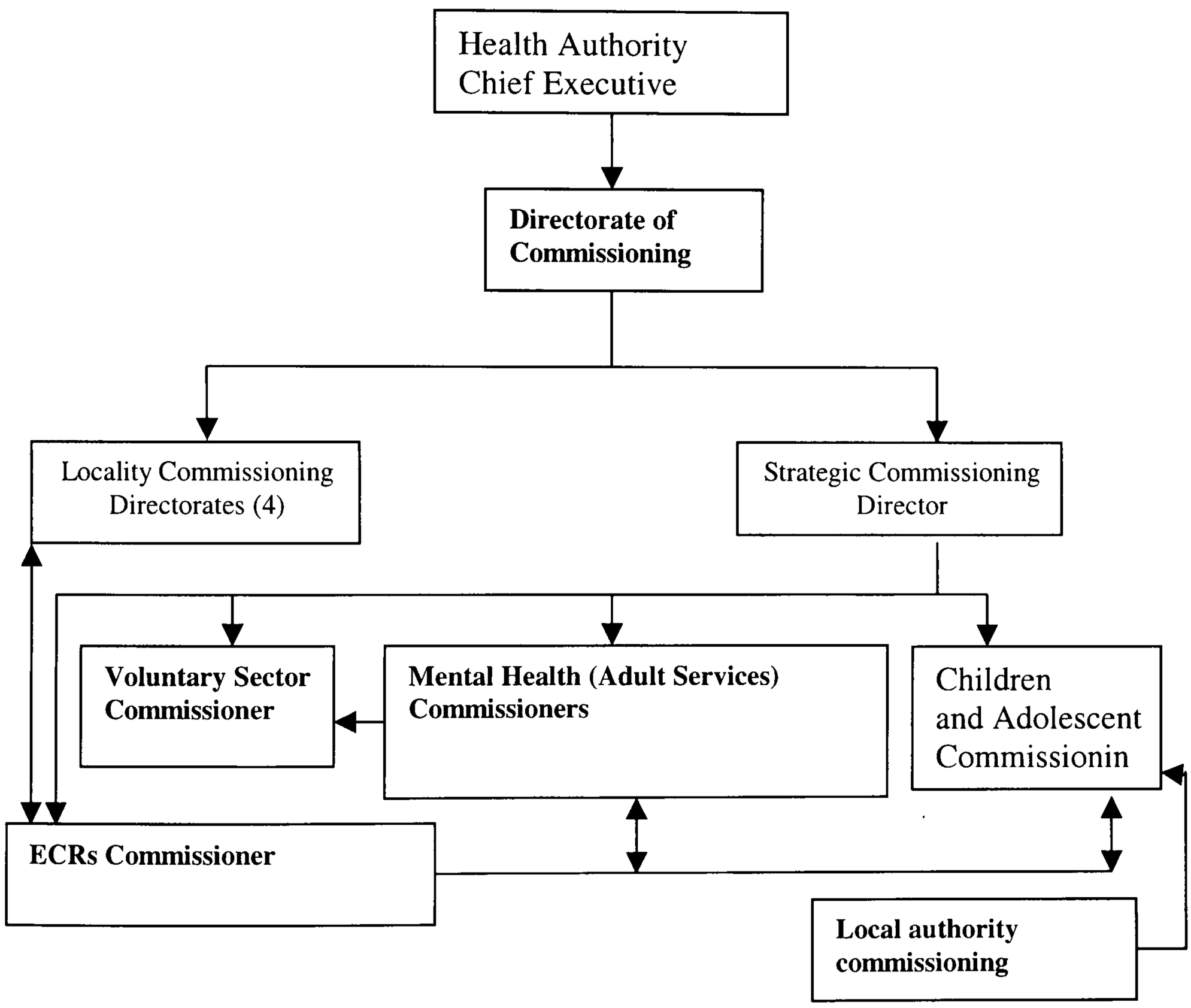

Figure 8.2
Structure of commissioning responsibility within the District

Not placing the commissioning of mental health services within the locality framework was at odds with the joint strategy, which emphasised the importance of shaping

[40] Localities were drawn to match the catchment boundaries of groups of GP practices

services at a local level with local primary care teams and GPs. The explanation for this may be a District concern to avoid political problems in relation to mental health services through direct control of the local mental health service agenda.

8.4(a) The configuration of General Practice commissioning

GP practices in the District were not uniform in their configuration, but reflected four different models. The first was the Total Commissioning Project (locally called the 'TPP'). This was one group practice in LA2, which purchased all health care (including in-patient specialist psychiatric services and all out-patient psychiatric services) for its patients (Gask *et al.*, 2000). The second was the "in-patient pilot project", consisting of two practices in one area. This was a "mini – TPP" focused on total commissioning in mental health for its patients. The third was non-fund holding GPs.[41] This group accounted for approximately 50% of all practices in the District as a whole. Finally, there were GP fund holders, which, at the time of data collection accounted for 35% of practices covered by CMHT A and 55% of practices covered by CMHT B.

The main means through which the District commissioners engaged with GPs on mental health issues was a GP Advisory group, which covered the entire District and with whom they met on a regular basis. The joint strategy set as a policy goal regular consultation and exchange of information between GPs and CMHTs at local level. This GP policy emphasis was reflective of the central policy desire to reverse the traditional balance of power between primary and tertiary care. How easily hospital based clinicians internalised this new policy emphasis would be a significant determinant of the degree of tension between the two sets of clinicians and between the District, the Trust and GPs.

Dialogue between the commissioners and local GPs did not mean that their relationship was without tension. In particular, the degree GP fundholders diverted the focus of CMHTs away from SMI and the apparent willingness of Trust management to accommodate their needs compared to those of the District.

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[41] That is those GPs who relied on the District Commissioners to purchase all health care for their patients

8.5 The contracting process

Contracts had to be agreed and signed before the end of March in order to run from April of any one year. The contracting process formally started in the September of the year preceding the contractual year with the publication of the District's commissioning intentions. These laid out the general aims of commissioning in the context of the financial constraints and issues that were likely to feature in the coming year.

During negotiations for the 1997/ 1998 contract the District announced that whilst it did not intend to cut its commissioning of mental health services, it did expect the Trust to absorb its own financial pressures in future contracts. In other words the Trust was not to pass on to the contractual price costs other than those for the service provided. In addition the District stated that it wanted to agree an activity price with the Trust by October 1996.

The apparent suddenness of this announcement and short negotiating time frame caused some irritation at senior Trust management level. The chief executive of the Trust complained:

> "I have been trying to find out for about six months before that just how much trouble they were in. Telling them that we would come up with much better plans if they told us quickly. Whereas, in fact in September we had to agree on activity price by October."

This is indicative of the frenetic resource pressures operating on contract negotiation at this time. Just how difficult these financial pressures became may be seen in relation to the activity price eventually agreed for highly specialist services, such as anorexia services, which was 1.5 million pounds for 1996/1997 - one million pounds short of the actual annual cost.

8.5(a) GP fund holders and contracting

The Trust received over £2 million per annum from GP fund holders. Whilst this may seem relatively small in the context of an overall Trust annual income of £45 million, in the context of financial constraints loss of such an income would be a significant.

An examination of the commissioning intentions of GP fund holders for 1997 appears to indicate that the Trust found it difficult to negotiate with this group compared to District commissioners. GP fund holders often required different services from one another. For example, each GP fund holder demanded different reporting methods and foci for reporting on contract performance.[42] A report produced for Trust management by the contracts' manager pointed out that the GP fundholders showed little concern as to how their immediate needs affected the District's insistence that Trust CMHTs focus on SMI.

8.5(b) Monitoring contract performance

Contract performance was monitored through four quarterly reports to commissioners produced by the Trust on the achievement of the Core Quality Standards that were negotiated between the District and the Trust. The commissioners required contract information on the level of implementation of central policy initiatives, such as CPA, activity returns on numbers of contacts for each CMHT and the supply of what was known as "the Common Information Core" required by the NHSE (Box 8.4).

- 100% valid post coding
- 100% valid GP coding
- 100% valid date of birth
- 100% valid ethnicity coding
- 100% valid consultant coding
- 100% gender coding
- 100% diagnostic coding

Box 8.4
Common information core

Information regarding the Trust's level of clinical activity for GP Fund holders and the TPP was also required. This was to monitor the degree to which the Trust was pursuing a primary care based strategy. However, it was also to ensure that GP fund holders and the TPP were not receiving favourable conditions of service and cost in relation to that received and charged to the District or distract the Trust from meeting the needs of SMI users.

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[42] Though it was Trust policy that each CMHT should meet with GP practices regularly to review performance

The forum through which this information was formally reviewed were quarterly meetings held between the mental health commissioners, the Trust Deputy Chief Executive, the Clinical Director and the Contracts Manager to review performance. The Chief Executive of the Trust and the Director for Commissioning for the District met to discuss strategic developments.

It was widely acknowledged that information systems upon which performance monitoring were based were neither accurate nor comprehensive. The commissioners' mechanisms for monitoring contract performance relied wholly upon Trust management to report on its own implementation, thus giving Trust management the opportunity to control information flow and content to commissioners if it should so desire. The dependency of the District on the information provided by the Trust was highlighted in the 1996/97 contract,

> "a detailed activity and quality monitoring report will be submitted to the purchasers at least one week before the date of each meeting."

Information requirements (See Box 8.4) focused on episodic accounting rather than assessing the quality of activity content. Information on the nature of users in the community and CPA implementation came from the Trust's annual "Long Term Case Register" report (See Section 8.2), which at the time of data collection was in its sixth year of publication. It appears that reliance on these data sources did not give a comprehensive picture of prevalence/ need. For anyone falling outside these groups the District and Trust management relied on returns from CMHTs through a computerised information system (CIS).

Each member of the CMHT completed monthly return forms on user contacts. The Trust management recognised that the items in the data return forms reflected information that was more pertinent to in-patient settings, for example bed occupancy and were in the process of an attempted correction at the time of data collection through the introduction of a new direct input computer based data collection system for CMHTs.[43]

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[43] This is further discussed in Chapter 9, Section 9.3

8.6 Conclusion

The District's overall policy strategy was resource led and cautious. It would appear that a key component in this strategy was to rely on the CMHT to meet needs. However, this posed a potential problem when set within an apparent policy rhetoric of user empowerment that might provide a point of practice reference for CMHTs which was contradictory to the resource position.

CHAPTER NINE

A Description and Situational Analysis of the Local Case Context – The Trust

9.0 Introduction

This Chapter describes the Trust context just prior to data collection. Section 9.1 provides a description of the operational configuration of the Trust, whilst section 9.2 examines its management structure. In this regard the internal debate on the issue of clinical leadership and the general orientation of the Trust as perceived by staff are described and examined. Section 9.3 discusses the introduction of the clinical information system. Section 9.4 goes on to discuss the Trust's financial position and this is followed in section 9.5 with an analysis of the Trust's 1996/1997 Business Plan.

Section 9.6 then discusses the 1996/1997 contract between the District and the Trust that was in operation at the time of data collection. Finally, concluding thoughts on the issues to arise from the examination of the case context are discussed in Section 9.7.

9.1 The configuration of the Trust

At the time of its establishment in 1995 the Trust's stated aims were to maximise its contribution to meeting the needs of the local population, use its resources efficiently and attract the highest "appropriate" level of resources to support its activities. The Trust was based on one main hospital site, a traditional psychiatric hospital dating back to the 1840s, supplemented by a number of out-patient facilities in the main general hospital. Employing 1200 people,[44]. the ratio of qualified to unqualified staff relative to other units in inner London was high, standing at 82% of the total workforce.

[44] 53% were nurses and 8% were doctors

The average number of patients under the Trust's care at any one time was 4600 patients of whom 390 were inpatients. The Trust provided adult mental health services to LA1 and LA2 and children and adolescent services to LA3. Services for MDOs, a regional substance misuse service, a regional service for mentally ill hearing impaired people and national services in a range of specialist therapies from cognitive-behaviour therapy to family therapy were provided. Services, such as acute admissions, were based in the hospital, though others, such as rehabilitation services, were based in the community. The Trust also provided 120 sheltered workshop places and two day hospitals, though one of these was closed during early 1997

The average caseload of each CMHT in the Trust (of which there were six in adult psychiatry) consisted of 66% long term mentally ill and the rest made up of neurotic illnesses, often termed less serious mental illness. Of the six CMHTs in the adult division, three were based on the hospital site whilst three were based in facilities situated in the localities that they served. The population served by each of the case study CMHTs was 48,000 for CMHT A (in LA1) and 46,000 for CMHT B (in LA2).

9.2 The management structure of the Trust

The Trust's operational structure, introduced in 1996 (See fig. 9.1), was a hybrid between a *machine* and *professional* bureaucracy (Mintzberg, 1983). That is one that involved vertical and horizontal specialisation, with divisions based around common functions; however it was also accompanied by horizontal and vertical job specialisation, with a degree of horizontal and vertical decentralisation.

The *machine* element of the organisation, focused on the overall functioning of the Trust, servicing and overseeing divisions. Their internal relationships were primarily managerial and regulatory, whilst their external relationships were primarily with statutory agencies. The *professional* element was organised along divisional lines, and focused on clinical services. Internal relationships were primarily inter-professional and based upon the concept of "team" and consensus (Onyett *et al.*, 1997). Their external relationships were of a boundary spanning nature encompassing professional organisations, similar professionals in other services and with users/ patients.

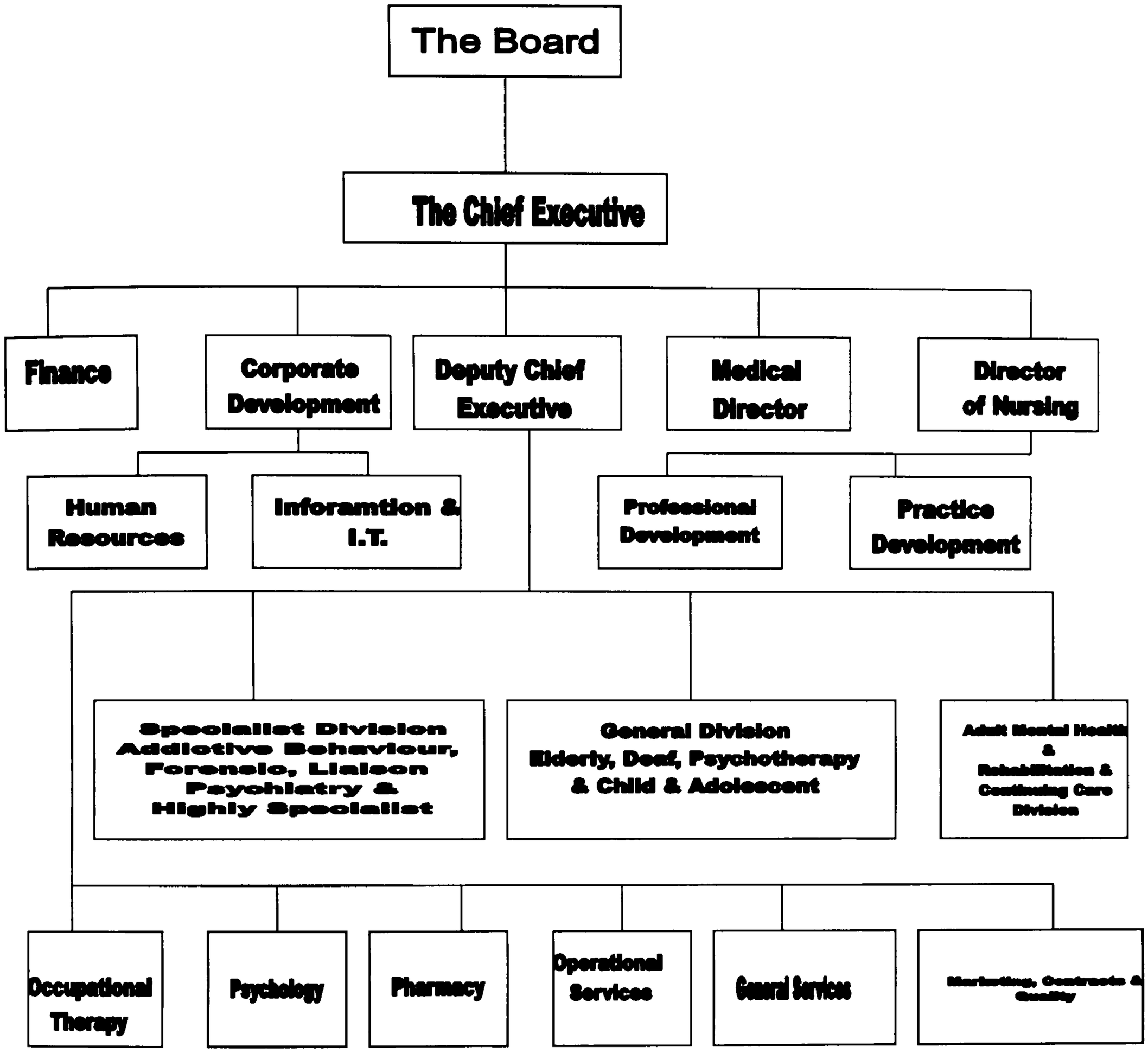

Figure 9.1
A simple schematic of the Trust's operational structure

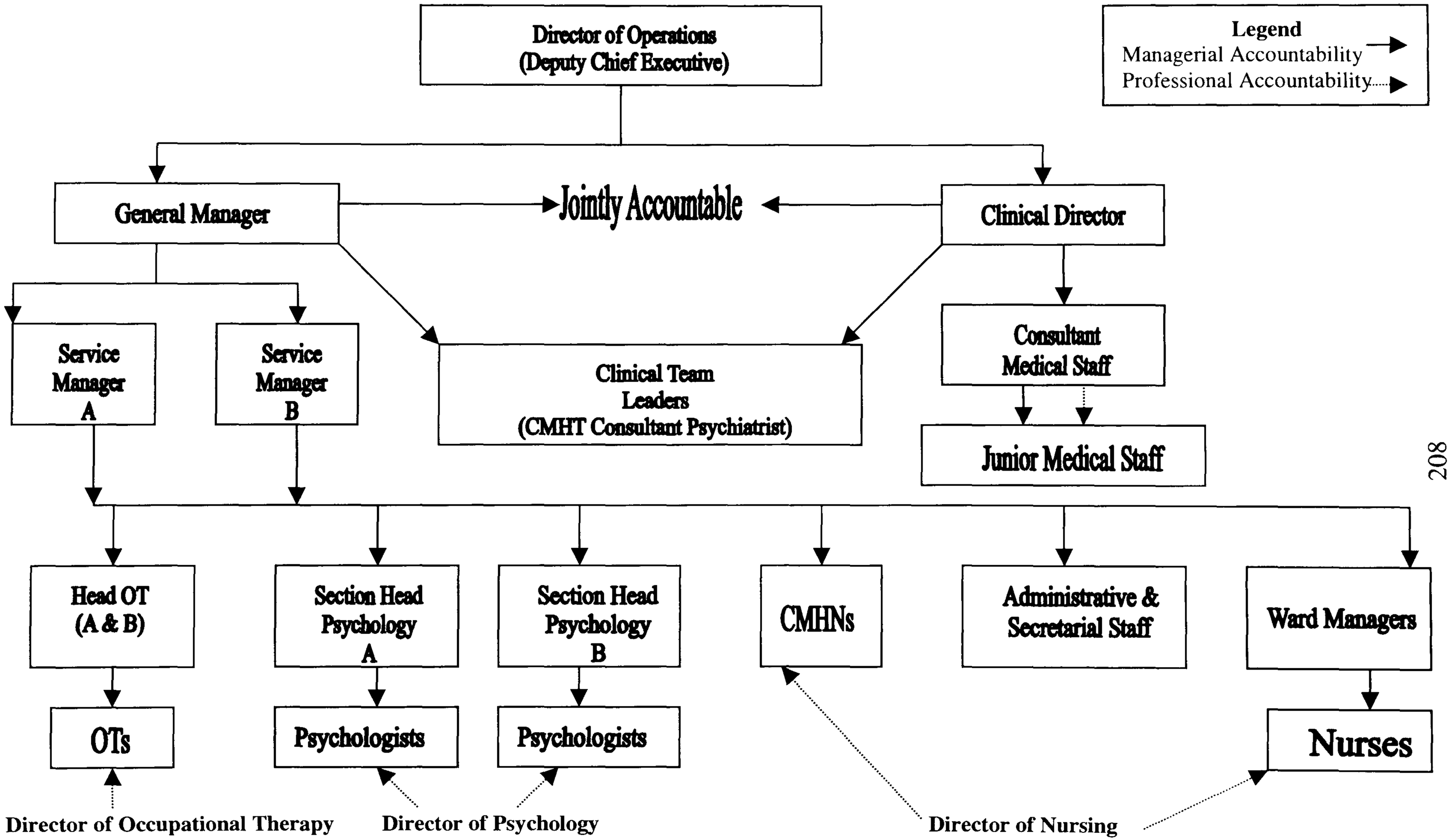

Figure 9.2 A schematic of managerial and professional accountability in Adult Division

The managerial accountability for each clinical division was shared between a general manager and a clinical director who were jointly accountable to the deputy chief executive[45]. A service manager had managerial accountability for all clinicians, with the exception of medical staff, (these were managerially accountable to the divisional clinical director), managed each of the clinical services within these divisions. However, the service managers had no accountability for the professional practice of these clinicians. This professional accountability was vested in the directors of the various clinical disciplines, for example nurses were directly accountable to the Director of Nursing for their practice (See fig. 9.2).

A *machine* bureaucracy is designed to deal with a context that requires regulation through a degree of external control of the work of staff by managers and through policy compliance. However, a *professional* bureaucracy tends to arise in order to encompass non-regulated complex contexts in which there is a greater emphasis on autonomous decision-making on the part of staff. The managerial structure of the Trust therefore had a potential to be a source of difficulty between staff and managers (Tremblay, 1998), based on a cultural tension emphasised through these structural divisions between what one might call the management and clinical groups (Dalley, 1993). Over the course of 1996 this appears to have manifested itself in two areas – the leadership of community mental health teams and the degree to which staff identified with the Trust.

9.2(a) Clinical team leadership

In January 1996 the issue of clinical leadership of CMHTs was discussed at a number of meetings between the Trust, local authorities and the District. The dominant role assumed by the consultants on this issue is indicated in the minutes, which note that, "the results of their deliberations will be shared with the purchasers in due course." A paper, drawn up by the clinical director for adult mental health services, argued that the consultant psychiatrist was already the implicit leader of the CMHT, and stated that formalised recognition was merely making explicit what was already implicit.

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[45] At the time when management interviews were conducted the post of general manager in the adult division was vacant and their duties were shared between the general service managers and the clinical director.

In February 1996 a Trust policy on Clinical Team Leadership was issued to staff for consultation. It stated that there was a strong pressure from the environment in which the Trust operated for clear lines of clinical accountability and that there was a need for a Trust response. It proposed that Clinical Team Leaders, who were to be Consultant Psychiatrists, would co-ordinate and decide on clinical priorities in the context of organisational priorities and be responsible for all aspects of team leadership as they affected multi-disciplinary working. They would direct the overall utilisation of resources and be held accountable for the priority given to individual users.

This proposal appears to have been a source of some discord within the Trust prompting, in April 1996, the General Manager of Adult Services at that time to circulate a memorandum to senior managers, clinicians and clinical teams on the proposal. This memorandum dealt with the concerns that had been identified as a result of the consultation. These primarily revolved around a perception that the autonomy of other disciplines was about to be infringed upon through an extension of medical power. It emphasised that the consultant was not to have managerial responsibility for staff from other disciplines; this responsibility was to remain with service managers.

- Attitudes towards the Trust's name
- How well informed are staff?
- Impact of changes on staff
- Identification and focus of staff
- Internal opinion of Trust's reputation
- Internal perceptions of image
- Internal view of Trust's strengths
- Internal view of Trust's weaknesses
- Effectiveness of communication with staff
- External view of Trust
- Attitudes towards service units
- Perceptions versus management vision

Box 9.1
List of areas addressed in Trust attitudinal survey

9.2(b) Staff attitudes towards the Trust

In July 1995, the Trust management commissioned an external assessment of attitudes and image held by Trust staff (See Box 9.1) and others (GPs the local Health Authority members, senior social service managers and representatives from other health

authorities). The external views were on the whole positive. Unsurprisingly, in view of similar studies done at around this time the views held by staff, particularly as they related to managers, were often negative (Wilkinson, 1995; Norman *et al.*, 1998). Clinical staff (such as nurses and registrars) appeared to be alienated from management, complaining of lack of consultation and the pace of change within the organisation. The report concluded that hostility towards management arose from a general sense of insecurity.

The degree to which the Trust management felt that staff disaffection could affect the implementation of policy within the organisation may be gauged from the guidelines that were issued during 1996 for a new system for gathering clinical information. This was in the process of establishment at the time of data collection in 1997.

9.3 The clinical information system

The Clinical Information and Management System (known locally as CIS), was a computerised data entry system. Gradually introduced during 1996 and the first half of 1997, clinical staff were required to enter patient demographics and a record of all their contacts with the patient. Its introduction was motivated, by a need to address the information requirements of commissioners and to provide evidence to the District of compliance with central policy objectives.

The original draft introduction to the guidelines on the systems use consisted merely of two sentences stating that the purpose of the document was to guide users of the information system as to what was expected of them by the Trust. In the final version there was a more fulsome introduction that was personalised in which it was emphasised that the CIS's purpose was "to help you with some of the problems that you have been encountering" when using the system. The introduction provided a rationale for the data entry system, which stated its importance in providing central government and purchasers with feedback on the performance of the Trust. However, in addition it appealed to self-interest through reducing workload,

> "... you can also now use a lot of the information entered to keep track of your patients and as an internal 'management' tool – the ward audit report will help us to phase out a lot of the manual forms you currently fill in".

There was also a requirement that staff enter contact data within two weeks of meeting with a client, which in the original document had been stipulated as five working days. In this draft there was no explanation for this requirement, though in the final draft an explanation was added,

> "Failure to do this may result in a patient being discharged before all contacts have been recorded and possible loss of income to the service due to incorrect data being recorded and subsequently passed onto purchasers".

It would appear that this explanation served a number of purposes. Firstly, it clearly indicated to staff the importance of information feedback in determining Trust income. Second, it had a sense of threat with the use of the opening word in the sentence "Failure", indicating a personal shortcoming on the part of the individual entering the data and of course an implied message that such failings could be examined. Thirdly, it demonstrated to staff that their contact with patients had a cost for which the Trust needed reimbursement, therefore raising the consciousness of the CMHT member as to the resource implications of their clinical contact.

9.4 The financial position of the Trust

The financial position of the Trust at the end of the contractual year 1995/1996 was modestly healthy. However the 1996-1997 Business Plan predicted that the coming contractual year would be financially strained. It emphasised that the District's financial difficulties meant that the Trust had to obtain "value for money". This was to be achieved through a rationalisation of the Trust's estate so that savings could be used to reduce the cost of services. Indeed, much of this document on first reading appeared to be concerned with protecting market share and reducing market exposure, thus indicating the broad concerns about costs, something that studies at the time found a commonplace concern amongst Trust managers elsewhere in London (Peck *et al.*, 1997).

9.5 The Trust's Business Plan for 1996-1997

The main strategic aims outlined in the Trust's Business Plan for 1996-1997 were the establishment of a 24 hour flexible community service and the achievement of a close

partnership with GPs.[46] The first two aims appear to be in response to a national policy priority to provide out of hours emergency support for users in the community and to demonstrate commitment to the policy emphasis on primary care, and particularly that of the GP, in the delivery of health care (NHS Executive, 1994a; b; 1995a). The last appears to be to demonstration of compliance with a long-standing policy emphasis on evidence based practice (Cooper, 2003).

The Business Plan stated that there was a priority to maintain and develop the Trust's links with GPs and to meet their requirements if the Trust was to "ensure that GPs refer to (The Trust Name) as the provider of choice for local and specialist services." However, the Plan also stated that there was a need to develop a strategy to ensure that general practitioners did not refer non-seriously mentally ill people to CMHTs, though this was couched in terms of reducing the workload on GPs.

The Business Plan described as "an investment in management" the operational structures that had been introduced as a result of the achievement of trust status in 1995. This in part may explain why the only point in the document where there was criticism of Government policy was with regards a requirement to reduce management costs by 5%[47], as it was argued that it would reduce the Trust's capacity to deal with change.

The Plan stated that during the previous year it had secured the involvement of senior clinicians at a corporate level and in the management of each service area, through the establishment of clinical directorates. The emphasis accorded to this change in managerial arrangements may be interpreted as a desire by the Trust to demonstrate senior medical support for their strategy.

9.6 The 1996/97 contract

At the centre of the contract for the financial year 1996 –1997, which was in operation at the time of data collection, were core quality and information requirements. There were requirements to implement the CPA and Government policy with regard SMI, resources and team working

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[46] See Appendix J for a comparative of the 1995/96 and 1996/97 Business Plans
[47] See Chapter Three, Section 3.3

- Demonstrate compliance by team with CPA and Supervised Discharge through quarterly returns
- Audit CPA as part of the clinical audit process
- Ensure timely and accurate information on community care is sent quarterly to the NHSE
- Work with the commissioners and local authorities to integrate into one system the requirements of CPA, Supervision Registers, Section 117, Supervised Discharge and Care management.
- Initiate and maintain training in CPA
- Introduce standardised documentation for CPA
- Ensure timely communication with GPs

Box 9.2
CPA specifications

The contract between the Trust and commissioners was a block contract with indicative episodic activity levels for each service funded by a mutually agreed level of value. The contract specified that service changes could not be made without the agreement of the commissioners, and that the Trust would devise a "Cost Improvement Programme" in consultation with the District.

In addition to the above, the contract specified that care had to be delivered in accordance with the standards laid out in the Patient's Charter (Department of Health, 1995d) and to meet the targets laid out in the Health of the Nation (Wing *et al.*, 1995). The contract specified that both the CPA and Supervised Discharge were to be implemented (See Box 9.2). Progress as to their implementation was to be reported upon in the quarterly reports. All initial assessments under the CPA were to consider whether or not an individual should be placed upon the Supervision Register. In addition, services were to follow the recommendations for the care of people with schizophrenia as laid out in the Clinical Standards Advisory Group Report on Schizophrenia (See Box 9.3).

Under the contract terms the Trust would be expected to conduct patient assessments for care on the basis of whether they met one of three referral criteria, that is emergency,

urgent and non-urgent[48]. In particular, the contract re-iterated the priority of teams treating individuals with SMI over other groups. However, it appeared to contradict the priority of this guideline by stating that, "it is expected that all providers should work collaboratively with practitioners to enable shared care wherever appropriate and effective consultation and advice to people of concern to GPs who may not be seriously ill". Thus at the heart of the contract was an implicit ambiguity of focus in terms of determining where CMHTs should focus their practice, since it failed to define the dimensions of "collaborative work", "consultation" and "advice".

- Set explicit local standards, in consultation with users and carers;
- Establish inter-agency working;
- Establish multi-disciplinary audit, emphasising clinical diagnosis;
- Implement the Care Programme Approach;
- Establish CPA patient-based registers and improve resources for areas of particular needs;
- Establish clinical leadership

Box 9.3
Recommendations for the care of people with schizophrenia as laid out in the Clinical Standards Advisory Group Report on Schizophrenia
(Department of Health, 1995b)

The main limits on ECRs included consultant psychiatrists seeking commissioner approval for referral on the basis of 'value for money' and that no other suitable alternative was available. The contract further limited the ability of consultants to refer directly to specialist psychotherapy services by insisting that such patients be assessed by a District nominated psychotherapist as to whether or not the referral should proceed. Thus the contract not only circumscribed the ability of consultants to refer their patients, but also demanded that they use economic criteria to justify their referral and that their clinical judgement be scrutinised.

Each CMHT was required to produce a brief annual report outlining its workload, team structure and activities with the local authority, key quality initiatives and concerns. This was not to be directly sent to the District mental health directorate, but was to be submitted to the Trust management who would then summarise it for the

[48] The level of urgency within these criteria was indicated through the degree of risk the referrer judged the individual to be and was reflected in the waiting times for CMHT assessment attached to each - one day for emergency; one week for urgent and up to four weeks for non-urgent. These local waiting time criteria however, stand in sharp contrast to those in the Patient Charter standards of the time which stated that a CMHT should assess a patient referred as urgent within four hours of receipt of the rerferral and within two working days for non-urgent referral.

commissioners. This in effect provided the Trust with an opportunity to control both the flow and content of performance information to commissioners.

The last element of particular note within the contract concerned the management of clinical risk. There was a requirement within the contract that the District's Chief Executive be notified of any untoward incident within 24 hours of its occurrence. Furthermore, the District reserved the right to impose its own investigation of an incident if it saw fit. It is interesting to note is that other than a reference to compliance with the recording procedures for Supervision Registers and Supervised Discharge, this is the only element of the contract that overtly addressed the most sensitive issue within mental health policy – the management of the behaviour of patients living in the community.

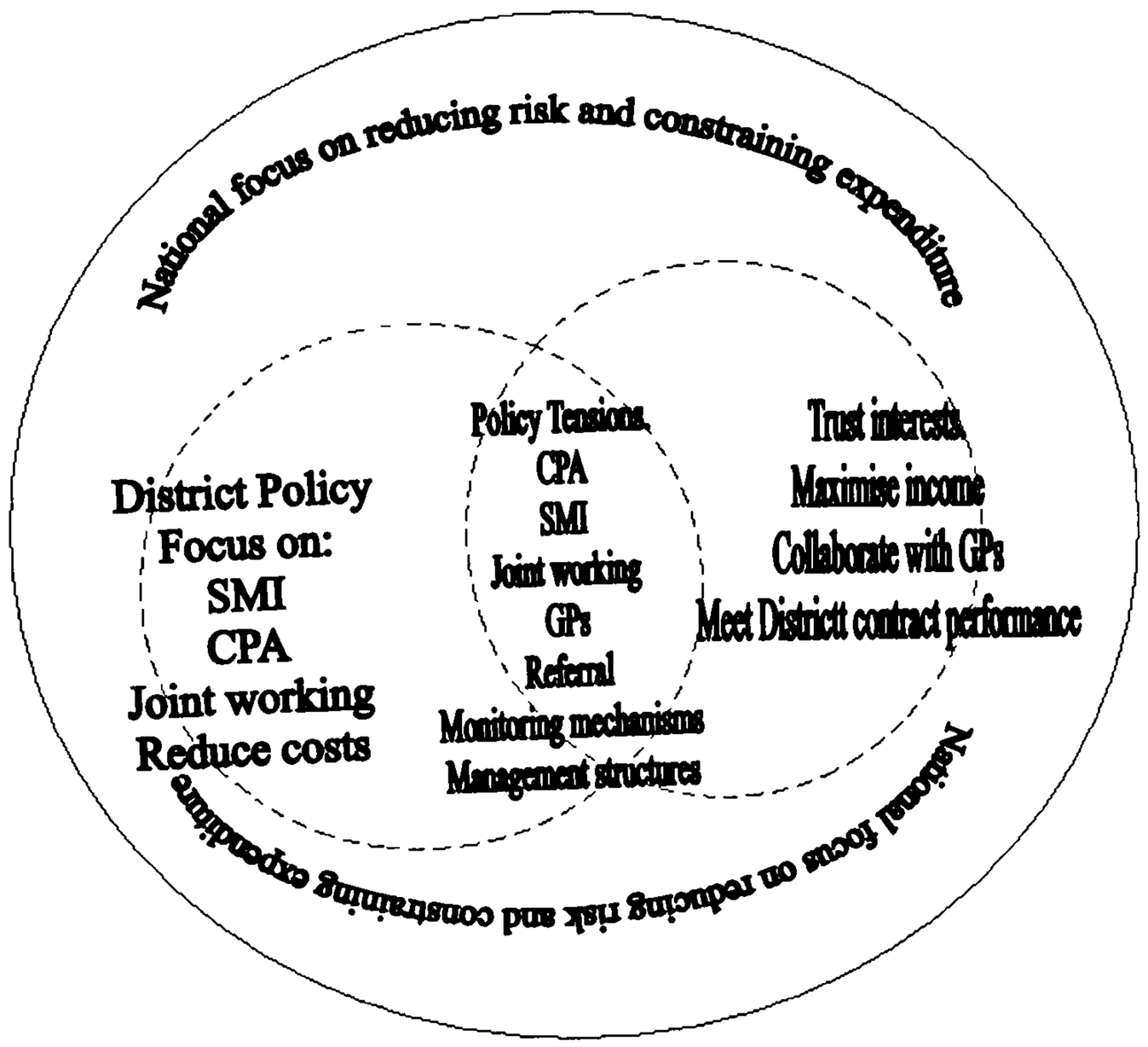

Figure 9.3
Local policy tensions

9.7 Conclusion

Overall, contractual arrangements emphasised national policy, particularly the CPA, Supervision Registers, Supervised Discharge and the importance of CMHTs in treating

those with SMI, (fig.9.3). However, these did not seem as prominent compared to commissioner concerns over ECR expenditure, in spite of the fact that there was evidence that CMHTs were still failing to conform to the requirements of the CPA, for example the number of users without care plans.

Within the Trust there was some tension between senior medical staff and other clinicians over the issue of clinical team leadership. This tension appeared to centre on the exercise of clinical autonomy and accountability of the professions allied to medicine as it related to the new leadership arrangements.

Central to many of these issues was the means employed to monitor performance. In this regard, the independence of information gathering and its communication was recognised as weak and inaccurate. In particular, a notable feature was the way that each level of the reporting structure had little means of independently verifying that the information that it was receiving was accurate. Thus CMHTs relied on the honest communication by individual practitioners of their activity in order to furnish Trust management with a report. In turn, the District commissioners relied on Trust management to furnish them with an assessment of their performance of contract outcomes. As a consequence both commissioners and Trust management had doubts about the veracity of at least some of the information they received. Whether these issues figured in the perceptions of individuals and groups within the case context is the subject of what follows.

CHAPTER TEN

Managers' Sense Making and Implementation Relationships: Perspectives on Policy

10.0 Introduction

This Chapter details the analysis of interviews conducted with Trust managers, the DHA commissioners and the DHA GP fundholder representative. It focuses on their views and understanding of policy and how these affected inter-relationships and implementation of it.

Section 10.1 outlines the issues that arose when accessing managers and provides background information on the sample, including those who took part in the group interview. In Section 10.2 data relating to the managers' cognisance of central and local policy is described and discussed. Section 10.3 concludes the Chapter outlining the main issues the data highlights and identifying the inter-relationship of uncertainty with dependency relationships as an important issue to arise from the analysis.

10.1 Access to and profile of managers

Managers were defined as those charged with the control of resources and who had responsibility for the receipt, interpretation and communication/implementation of central and local policy to the Trust and CMHTs. A group of managers who were identified as significant for understanding the local context in which the Trust operated were commissioners of services. The principal commissioners of services were identified as managers in the DHA and the GP fundholders. The former were accessed via a letter to the DHA Director of Commissioning, requesting an interview.[49] However, on the day appointed for the interview she felt that more would be learned from the commissioners directly charged with purchasing mental health services rather than from

[49] I thought at this interview I would ask her to nominate others in the DHA who I would then subsequently approach to interview

her. She therefore had arranged for one of them to be interviewed in her place and a second had been informed that they would be contacted (See Table 10.1). In a sense therefore the issue alluded to in Chapter 7[50] when accessing CMHTs had also occurred in this context - that is the power of the gatekeeper to influence the research process and the issue of the degree to which participants freely exercised an autonomous decision to be interviewed.

Through the subsequent analysis and reflection on the issues it was realised that the DHA Chief Executive had an important relationship with the Chief Executive of the Trust at a 'political' level. Therefore, on reflection, it was an error not to press for an interview with her more vigorously at that time.

The second commissioning group were GP fundholders. Since this was a large and disparate group of stakeholders in relation to the CMHTs and had limited time for data collection it was decided to interview their representative with the DHA. Whilst valuable information was gained from this informant, by the very disparateness of this group, on reflection a larger sample within a group interview setting may have enhanced analysis. Unfortunately, it was not possible to establish such a group within the time frame available once having reached this conclusion.

10.1(a) Accessing Trust managers

Accessing Trust managers for individual interview followed a three-fold strategy. The first was to identify initial informants that were suggested by the research issues - the Chief Executive of the Trust and the two service managers of the two CMHTs. The second was to follow a rolling strategy in which the last manager to be interviewed was asked who they thought would be a useful informant. The third was to utilise personal knowledge of the Trust when engaged in the initial review of each interview to identify potential respondents.

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[50] See Section 7.3

Sample unit	Professional Background	Gender	Years in Post (at time of interview)
DHA Commissioner (DHAC1)	Psychiatric nurse	M	1 year
DHA Commissioner (DHAC2)	NHS Administrator	F	2 years
GP Fundholder DHA Representative (GPFH)	Medical	M	10 years
Trust Chief Executive* (CEO)	Consultant psychiatrist	F	4 years
Deputy Chief Executive (DCEO)	NHS Administrator	M	4 years
Trust Clinical Director, Adult Services, Trust*(CD)	Consultant psychiatrist	M	2 years
Trust Chief Nurse Adviser (CNA)	Psychiatric nurse	F	Six months
Assistant Director of Nursing Services (ADNS)	Psychiatric nurse	F	2 year
Trust Contracts Manager, (CM)	Psychiatric nurse	M	2 years
Trust service manager 1, CMHT A (OPM1)[51]	Psychiatric nurse	F	1 year
Trust service manager 2, CMHT B, (OPM2)	NHS Administrator	F	1 year

Table 10.1
Profile of the DHA and Trust management interviewees

(* These individuals had in fact been employed within the Trust long before it achieved Trust status in various clinical and managerial capacities going back in the case of the clinical director to the 1970s)

[51] I coded the service managers as OPM (operational manager) because within the literature this is the term used for managers at this level. Service manager refers to their official designation within the Trust.

Eleven managers were approached within the Trust of whom nine agreed to be interviewed. Unfortunately, one interview tape was inaudible for the purpose of transcription.[52] Therefore eight Trust manager interviews were transcribed for the purpose of analysis.

Generally, Trust managers were very willing to be interviewed and surprisingly forthcoming within the context of a highly politicised mental health environment[53] in which resource cuts and the results of the staff attitude survey indicated a degree of local sensitivity around many of the issues of interest.[54]

The overall interview process came to an end when it was felt that a sufficient range of people had been interviewed to make analysis meaningful. This decision was taken in relation to two points of reference - the level of repetition of issues that started to occur (a modified data saturation) in relation to the literature and research questions.

Sample unit	Professional Background	Gender	Years in Post (at time of interview)
CMHT Operational Manager (OPM3)	Psychiatric nurse	F	2 years
Deputy Chief Nurse Adviser (DCNA)	Psychiatric nurse	F	1 year
General Manager, Mental Health Adult Services (GM)	Psychiatric nurse	M	6 years

Table 10.1(a)
Profile of manager group participants

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[52] I did not take notes during taped interviews and decided not to ask the respondent for a second interview since she was under a considerable degree of work and personal stress at this time.
[53] See Chapter Two and Three
[54] See Chapter 9, Section 9.2

10.1(b) Accessing group interviewees[55]

For the purposes of the group interview managers were approached in two other mental health Trust hospitals in the London area. The reason for going outside the Trust was that the availability of managers within the Trust itself for a group interview of equivalent managers to the sample was limited by the uniqueness of their positions.

Four managers were asked to participate in the group interview. All four agreed however on the designated day one participant cancelled. Therefore, three managers actually took part in this interview (See Table 10.1a). The interview itself was held in January 1998, conducted in a comfortable meeting room at King's College London, tape-recorded and transcribed.

10.1(c) 'Typicality' of managers

It will be noted that the average time each individual interviewee had been in post was 2.5 years. However, this figure includes the 10 years the GPFH had been a local GP. If one removes him from the calculation the average period individual interviewees were in post was 1.75 years, thus indicating a lack of experience within the specific Trust environment. However, this in fact was not the case since many of the managers had held senior posts either in the hospital prior to it achieving Trust status, (for example the CEO had been the hospital General Manager and prior to that the deputy General Manager) or senior posts in mental health elsewhere (for example the DHA commissioners).

Peck *et al.* (1997) reported at this time in their analysis of 78 senior managers of mental health services in London, the only such survey conducted at the time of data collection, that over 50% had been in post for less than two years but that more than 50% had worked continuously in mental health for five years or more. They reported that 57% had aggregate experience of working in mental health for 11 years or more.

Thus it would appear that the experience of the majority of the individual managers interviewed for this study were fairly typical for managers in the London area in terms

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[55] The data generated from the group interview with managers will be dealt with in Chapter 11.

of length of experience and years in post at that time. There were three exceptions to this typicality within the sample since these were in their first senior posts (the CNA, ADNS and CM). Each had come from senior clinical mental health nursing posts rather than through a nurse management route.

In terms of gender, the respondents had a slightly stronger female representation than that to be found in Peck *et al.*'s survey (1997) with 57.1% compared to 43.8%. Thus there was a marginal atypicality in this regard compared to this survey.

Another notable feature about the respondents' profile was the number of managers with a clinical rather than managerial background (in the case of the CD, who also continued to function as a consultant psychiatrist, and the CNA and the ADNS, who had overall joint responsibility for maintaining professional nursing standards, their clinical identity was con-joined with their managerial role). The number of individuals drawn from mental health nursing is also notable, accounting for 61% of all managers interviewed (excluding the GPFH). This clinical profile seems fairly typical. For example, Peck *at al.* (1997) reported in their survey that 70% of managers had a clinical background. However, they reported a smaller number from mental health nursing, accounting for 22.81%. Therefore compared to this larger survey the specific clinical profile of the interviewees was atypical.

One could argue that this particularly strong mental health nursing profile may be a result of bias resulting from the interaction of my purposeful interviewing strategy and my own professional background. The group interviewees were selected through a degree of bias since they were known through previous professional contact, though they were selected because of their managerial status.

Overall, the interviewees seemed to reflect the broad profile to be found in London mental health services at this time. The managers who agreed to be interviewed demonstrated a willingness to talk about national and local mental health policy issues. Where a reluctance was displayed this appeared to result from a fraught relationship

with one CMHT, which was known by the particular manager concerned to form part of the study sample.

10.2 Views on policy

Writers such as Weick, (1995), Sabatier, (1998) and Spillane *et al.*, (2002) argue that individuals' consciousness of policy and their beliefs about it have a direct bearing upon their understanding and response to it. Garn (1999) argues that local implementers' motivation to embrace a policy objective is essential if they are to adhere to the spirit of the policy goal and generate the effort necessary for its successful implementation. This Section examines the specific Government and local policies that were raised by managers during interview (See Table 10.2), describing their opinions of these policies with reference to policy engagement thereby indicating their significance for implementation.

10.2 (a) Policy can be contradictory

Commonly mentioned central policy issues were the Government focus on SMI and the promotion of primary care as a central foundation of existing and future health policy development (See Table 10.2). Though each was discussed in its own right, a number of managers also inter-related the two. This is not surprising bearing in mind the debate between DHA commissioners, the Trust and GPs on the relationship of GP fundholder referral to diverting the focus of CMHTs away from SMI.[56]

A number of managers identified GP fundholders as an important policy difficulty that needed to be managed. They saw them as introducing a confusing lack of standardisation, contradicting other policies such as the SMI focus and a waste of resources. For example the DCEO and the CD believed that the influence of fundholders would make a coherent mental health policy and care approach impossible.

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[56] See Chapter 8, Sections 8.4a

Policies	HoNoS	CPA	SMI	Supervision Register	Supervised Discharge	Patients' Charter	Strategic Plan	Clinical Audit	Primary Care	Locality Commissioning	Joint Working	CMHT leadership	Resource policy
Sample unit													
ADNS	0	1	1	0	1	0	0	0	1	0	0	0	1
CD	0	1	1	0	1	0	0	0	1	0	1	1	0
CEO	1	1	1	1	1	0	0	0	0	0	1	0	1
CM	0	1	0	0	0	1	0	1	1	1	1	0	0
CNA	0	1	1	1	1	0	0	0	1	0	0	1	1
COMM1	0	1	1	0	0	0	0	0	1	1	1	0	1
COMM2	0	0	0	0	0	0	1	0	0	0	1	0	1
DCEO	0	0	1	0	0	0	0	0	1	0	1	1	1
GPFH	0	0	1	0	0	0	0	0	1	0	0	0	1
OPM1	0	1	1	0	1	0	0	0	1	0	1	1	0
OPM2	0	0	1	0	0	1	0	0	0	0	1	1	0

Table 10.2
Policy cognisance
(1=coded; 0=uncoded

The DCEO drew attention to the policy contradiction arising from the central exhortation to focus on SMI whilst ignoring the overall strategic policy aim to promote GP power to determine tertiary responses to meet primary care needs. A number of managers pointed out that the majority of patients for whom GPs cared suffered from transitory mental health problems, whilst people with SMI, epidemiologically, were a minority of most GPs' caseloads and therefore not as likely to be seen by GPs as the primary patient group in terms of workload numbers for whom assistance would be sought.

10.2(b) Assertive collaboration and uncertain impact

The GPFH stated that GPs tended to refer patients with any form of suspected mental health problem to the CMHT. He explained this as arising out of a lack of clinical alternatives to the CMHT for non-SMI patients combined with a fear of public opprobrium consequent of such *cause celebres* as the 'Clunis affair'[57] should they be found wanting later with regard any untoward incidents resulting from undiagnosed SMI. In other words a form of contingency risk management motivated such referral as a result of the general policy atmosphere and limited clinical resources.

A holistic reading of his transcript indicated a general concern not to undermine national policy in relation to SMI and the Trust. However, this was tempered by an assertive tone in relation to the power he was prepared to exercise in order to determine services to meet his needs. He seemed to view the future relationship of primary care in relation to mental health services as a collaboratively assertive one.

> "Certainly if it moves to GPs they will wield power. Now, as I said earlier, some of them can be real mavericks but I think if they have greater purchasing and commissioning power they may use that and put more pressure on us and may not be hoodwinked by some of our clinical arguments. At the same time it will be interesting to see how that goes."
>
> **Trust Contracts Manager**

Box 10.1

Assertive collaboration

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[57] See Chapter 2, Section 2.5; Ritchie, (1994)

Most Trust managers recognised that the thrust of government policy regardless of the election outcome would increase the influence of GPs in commissioning processes. Most expected the abolition of GP fundholding and its inevitable replacement with some form of primary care group commissioning.

DHAC1 thought the expansion of primary care commissioning would initiate positive service changes, which may be seen as an admission of the limits of the DHA to initiate such change alone. Some managers, both DHA and Trust, said that there would need to be a more collaborative relationship between primary and secondary care. However, a number of Trust managers expressed concern about the degree to which GPs would assert an authority over secondary services that would impinge on the Trust's power to shape the local care agenda (See Box 10.1)

From these contributions one may discern a relationship between policy uncertainties about the future in terms of agenda control. In particular, a focus of some managers on the degree to which future policy development would temper or improve the Trust's power to determine and order the local policy relationships.

"Now if you look at the Medical bit of psychiatry just for a second medicine and nursing as the two main disciplines when I was a medical student psychiatrists were strange people did they become psychiatrists because they were odd or did psychiatry make them odd. Whatever it was they were demonstrably odd. They had charm but it doesn't give a lot of confidence. … I think we're dealing with it better now despite society's change. Society is much less deferential to the professions."

Trust Clinical Director of Adult Services

"Em, I hesitate because the things I think, the headline national issues are confidence - that confidence exists nationally in the local services delivering the kind of service that everybody thinks there should be provided;"

Trust Deputy Chief Executive

Box 10.2
Gaining and retaining public and political confidence

10.2(c) Public confidence and defensive prescription

Some managers spoke about retention of public and political confidence in psychiatric services as an important policy issue in terms of underpinning the organisation and delivery of local services. In particular, the CD and the DCEO raised this as an issue.

Lack of confidence in professional psychiatric services was seen as resulting from the interaction of well-publicised violent incidents with the public stereotypes of mental health clinicians. Consequently, both central policy and the Trust were required to respond (See Box 10.2).

> "The thing about mental health is that it is the only area where services are really on the receiving end of such precise instructions about how they see things. A relatively small example, if you look at the supervision register its essentially mandatory; we don't have any choice about that whether we think it is the right thing or not."
>
> **Trust Chief Executive**

Box 10.3
Criticism of central prescription of mental health care delivery

As Table 10.3 indicates there was a tendency to voice negative criticism of policy. Thus a number of negative opinions were expressed about the degree to which mental health care was prescribed by central Government from a perceived defensive mindset. Some informants complained about specific initiatives and others about a more general policy environment of interference in which it was increasingly difficult to operate and manage services flexibly (See Box 10.3).

10.2(d) The interface between perceptions of central prescription and the 'health' of the Trust

Criticism of central government prescription was based on a view that it lacked sensitivity to the nature of mental health care and had a tendency to alienate staff through the manner in which policy was promulgated or imposed requirements without sufficiently delineating structures/ processes of implementation. The CPA was particularly criticised in this regard (See Box 10.4). Indeed, one of the factors that marked a positive opinion of policy was whether or not it permitted flexible application to meet local needs. Thus the Health of the Nation Outcome Scales, were seen as a useful service support because they could be selectively applied to meet local needs.

Opinions	Prescriptive	Over focused on containment	Insufficiently resourced	Ambiguous and contradictory	Politicised	Attempting to restore public confidence	Need to better integrate services	Uncertainty about impact on Trust	Potential to improve services	Wasteful	Fait accompli
Policies											
HoNoS	0	0	0	0	0	0	0	0	1	0	0
CPA	1	1	1	1	1	0	0	0	1	0	0
SMI	1	1	0	1	1	1	0	0	1	0	0
Supervision register	1	1	0	0	1	0	0	0	0	0	0
Supervised discharge	1	1	0	0	1	1	0	0	0	0	0
Patient's Charter	1	0	0	0	0	0	0	0	0	0	0
Strategic Plan	0	0	1	0	0	0	0	0	0	0	1
Clinical audit	1	0	0	0	0	0	0	0	0	0	0
Primary care	1	0	0	1	1	0	0	1	0	1	0
Locality commissioning	0	0	0	0	0	0	0	1	0	0	0
Joint working	0	0	1	0	0	0	1	0	1	0	0
Clinical team leadership	0	0	0	0	1	1	0	0	1	0	0
Resource policy	0	0	1	0	0	0	0	0	0	0	1

Table 10.3 Management opinions on specific national and local policies (1=coded; 0=uncoded)

"I mean no one has a good word to say about the Care Programme Approach. I mean, as I said, the doctors resisted it actively. Nurses, and people like that, they too couldn't understand why they had to fill in several pieces of paper and what was wrong with the system before?"

Trust Assistant Director of Nursing Services

"For instance care programmes the way that that was introduced by the Government created a fair amount of ill feeling because it implied that people were not practising professionally and that they needed civil servants to tell them how to do it."

Trust Chief Executive

"Well I think we have resolved that. I think basically CPA is one of these things where there was this failure to say what was policy and what was practice but the way we have resolved it is by saying we will drive it professionally and if that causes problems for administration let us know and we shall see if we can accommodate it and the managers are very happy with that."

Trust Clinical Director of Adult Services

Box 10.4
Policy disaffection

These issues combined in a number of interviewees' expressed concerns on the central policy emphasis on containment and its implementability. The CM and OPM2 critiqued what they saw as blanket prescriptions of the Patient's Charter, which they felt often had very little relevance to what could be achieved within the local mental health service whilst the CD and ADNS critiqued CPA for its lack of differentiation between objective and process, articulating broad operational parameters and expectations without supportive specifics. They all described how the Trust had selectively implemented elements of these policies as a consequence, effectively ignoring those parts not considered relevant to local conditions.

Most managers saw the delivery of services to the SMI as the defining characteristic and priority of tertiary mental health care. Equally, the principle of the CPA was supported. For example OPM1 said it had the potential to improve inter-professional co-ordination in the delivery of care, whilst the CEO said she had yet to meet anyone who disagreed with it in principle. The CM stated that the CPA had become 'vitally important' to the Trust because, it enhanced the monitoring of care implementation. Yet these general statements of support were qualified in terms of specific operational issues. For example, central government was criticised for failing to provide a clear definition of what constituted SMI.

Some managers' felt that the manner in which CPA had been promulgated by central Government had served to alienate many clinical staff from supporting the policy, making it more difficult for managers to win implementation cooperation (See Box 10.4). The CEO and the ADNS felt that central policy had failed to acknowledge that the CPA articulated what were generally standard clinical practices. A number of managers (the CEO, the ADNS and OPM1) said that clinicians saw it as adding to their administrative burden and therefore resented it as such.

A number of points arise from these comments on policy. The first is that a number of managers appeared to absolve themselves of responsibility for how staff perceived central policy, despite the fact that they were charged with conveying such policy to clinicians. This, it could be argued, was a distancing tactic not only from responsibility for the perception of policy but also from responsibility for policy consequences.

The second is an implicit criticism of policy not in terms of its merit but in terms of the degree to which it added to tensions between managers and clinicians. Policy that was seen as burdensome and unnecessary by managers was characterised by some as a source of operational difficulty between themselves and clinicians. For example, the CEO and the CNA acknowledged that it was proving difficult to motivate staff to use the Supervision Register (the CEO and the CD), about which managers themselves had expressed misgivings. Supervised discharge was mentioned by a number of managers as a policy that the Trust was required to implement but was viewed as a political imperative rather than a practice necessity. Indeed, the ADNS pointed out that the Trust had only one patient on such an order.

10.2(e) 'Capacity' perspectives on policy

The 'opportunity costs' associated with the focus on SMI were raised by the ADNS, who pointed out that GPs were caring for patients with transient psychological/neurotic illnesses that tertiary care services would've previously dealt with. Whilst there was a stated operational acceptance of the policy focus on SMI, for example the CEO stated that CMHTs would need to be more robust in rejecting referrals of non-SMI patients, a number of managers displayed in their utterances either direct or indirect discomfort

with the notion of the Trust's generic service exclusively focusing on this patient group. Thus the CEO also said that the Trust would have to provide advice and assistance to GPs to deal with their 'worried well' (non-SMI) patients.

The CD supported the emphasis on SMI because he believed in the need to prioritise care within a context of restricted resources, but later stated his discomfort with such a focus on the grounds that it would isolate both patients and the psychiatric profession from the wider community. His stance is curious since the CNA reported that he was a significant proponent of the SMI focus in the Trust.

The DCEO displayed a more consistent line of thought. He stated that the central policy focus on SMI was in effect a misapplication of resources since they formed only a small minority of the total population of the mentally ill. He also went on to state that the transfer of resource distributive powers to primary care would mean that the needs of non-SMI patients would inevitably become an important local priority in the long-term.

> "...and that for those people with less serious mental health problems, whilst some of them may appropriately come to a secondary care service there's also a need to strengthen and enhance primary care; and though that isn't necessarily our business, it might be appropriate for us to support and supervise in that situation. But we don't see it as a core business for us."
>
> **Trust Chief Executive**
>
> "The average population of the GP would have between four and six people who might be defined as you know, seriously mentally ill. Now you'll know that seriously mentally ill people gravitate to GPs that are sensitive to their needs, so it is not an exact science, which you will find some clients have an awful lot of people that are seriously mentally ill, but that is not an exact study because you forget, but on average you would expect a handful of people within the practice to come in, to be defined as such and yet vast quantities of cash seem to get spent on that small amount of people."
>
> **Trust Deputy Chief Executive**

Box 10.5
Capacity perspectives on policy
*text here changed since CNA named individual

What might explain these nuanced differences of perspective is the interaction of a duality of capacity amongst individuals who were clinicians by professional background but who were also in general management positions (See Box 10.5). Zerubavel (1999) points out that sense making of policy by individuals takes place with reference to their

'thought communities', that is their social and situated contexts, for example professions and organisations, which serve to shape individual cognitive processes.

In their general management capacities, managers from a clinical background supported the Government exhortation to prioritise the SMI focus. This may have been informed by an acceptance of the organisational context of resource constraints[58] and an internalised economic rhetoric of priorities,[59] as demonstrated by the CD belief in the need to prioritise. However, in their capacity as clinicians, they had some misgivings and perhaps found it harder to separate from the traditional values within their professional 'thought community' of providing comprehensive care to the whole rather than a targeted population.[60]

Alternatively, the DCEO was able to exhibit a more consistent critique of policy set against an internalised managerial construct of 'economic man' and population-based assessment of resource distribution that referred to utilitarian concepts.[61] It may be argued that this was because his management capacity resonated both with his situated 'thought community' – the Trust and pressure on resources - and his social 'thought community'- his professional background as an NHS administrator. Thus, whilst both types of manager come to similar conclusions about policy, the process and perhaps the accompanying affective impact on each is different.

10.2(g) Matching external expectations to internal needs – the 'comfort' of authority

The CD, the CNA, OPM1 and OPM2 discussed clinical team leadership with reference to the contention that it had raised within the Trust.[62] The CD said that it had been decided to make the consultant psychiatrist the clinical team leader because external factors such as the new mental health legislation and the expectations of those who came into contact with the CMHT, for example GPs, needed to match with an internal structure of *authority* (Obholzer, 1994) within the CMHT (See Box 10.6), in this context formally empowering consultants to have a binding power on the management

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[58] See Chapter 8, Section 8.3
[59] See Chapter 4, Section 4.4
[60] See Chapter 3, Section 3.3 and Chapter 5, Sections 5.1 and 5.2d.
[61] See Chapter 4, Section 4.4 and Chapter 11, Section 11.2.
[62] See Chapter 9, Section 9.2a

of patients and the distribution of clinical work, though not managerial responsibility.[63] He acknowledged that this was controversial within the context of inter-professional autonomy, and particularly drew attention to the position of psychologists in this regard.

> "... we have said explicitly, and I think implicitly is the case, that the consultant is the clinical team leader because we feel that the reality of the external expectation and the internal ability to discharge them has got to be matched."
>
> **Trust Clinical Director of Adult Services**
>
> "there was also sort of difficult issues decreasing medical staff, for instance, particularly at consultant level and I think there was a strong lobby from the consultant psychiatrists to get behind them and support them and that was one way of indicating to staff that we were going to do that and eh, and actually we need the Consultant Psychiatrists on our side and they have a very important job to do, its very clear that we can't run a service without them."
>
> **Trust Operational Manager 1**
>
> "No, as an Operational Manager from a purely practical point of view, it makes my life easier, because there is one identified, explicitly identified person who I know is responsible for the delivery of the clinical service and therefore my role within the team is also easier."
>
> **Trust Operational Manager 2**

Box 10.6
Moving to the 'fully managed team'

The CD argued that the change away from the 'democratic' concept of team management, the traditional model employed in the Trust, to a hierarchically based one (reflecting what Onyett (2003) refers to as a 'fully managed team' model) was prompted by the increased prescriptive nature of central government policy, particularly in the area of containment and patient supervision; with a concomitant need to have one point of authority within the CMHT that was commensurate with professional statutory responsibilities. The change could therefore be seen as a response to a politicised practice environment.

However, the CD also implied the change was prompted by a need to establish an accountability for the management of CMHT resources within the local context of priorities. The contributions of the two operational managers also reveal local drives for change. OPM1 felt that placing the consultant psychiatrist in charge of the CMHT was an attempt to reassure Trust consultants that management recognised the importance of

[63] See Chapter 9, Section 9.2a

their role and to arrest local difficulties in recruiting medical staff to these positions. Alternatively, OPM2 indicated that she had found it difficult to identify with whom to negotiate in relation to operational matters. Having an identified authority within the team would solve this.

The leadership policy was recognised as having introduced a degree of tension within the organisation between managers and other clinicians and internally within the CMHTs. The DCEO, though he specifically mentioned conflict with psychology also indicated that other members of the CMHT resented the consultant clinical leadership role. OPM2 said that she felt that the tension around team leadership was principally between psychology, OT and social work, but that nurses had been far more accepting of the change because they were not trained to think of themselves as rivals to the medical profession.

However, the CNA felt it had caused problems in terms of the question who determines the practice content of professionals, citing consultant use of their leadership position to restrict the role of nurses in patient care which, she claimed, had prompted some to leave the organisation. OPM1 said that clinicians within the CMHT had perceived the change as a policy statement that teams were to follow the medical model, though she denied this was the case. She also said that non-medical clinicians within the CMHT, and particularly psychologists, saw the Trust decision to impose consultant psychiatrists as team leaders as a pre-emptive attempt on the part of management to interfere with clinical autonomy.

Despite these perceived resentments, for managers, the benefits of the policy change outweighed the negative impact they perceived that the reconfiguration of leadership had had on the morale of CMHT members. Generally managers appeared to view this local policy as a positive development in which external policy stringencies and expectations matched their internal needs for clarity and support of authority which, one might argue, resonated with the traditional management credo of ordered structural relationships and the need to reduce spans of uncertainty (Clegg and Palmer, 1996; Wells, 1999). It would appear to be an attempt to create an 'arena of agreement and co-

ordination' between Trust management and Consultant Psychiatrists by establishing an authoritative structure through which a more compliant policy implementation could be achieved (Gunn, 1978).

10.2(h) Joint working – systems barriers, practice 'seepage'

The CM critiqued the Government exhortation for closer working between Trusts and other agencies (Department of Health, 1995a), such as social service departments. Peck *at al.* (1997) found the issue of joint working was an important concern for health service managers in London.[64] However, most managers in this Trust did not see the issue as a significant policy concern. As indicated in Chapter 8 joint working with one of the local social services departments and integration of its social workers into the CMHTs had been established at the time of data collection.[65] Indeed, compared to the rest of the country the Trust was ahead of most mental health services in this respect (See for example, Gulliver *et al.*, 2003).

However, negotiations on integration with LA2 were somewhat more intractable and levels of system and operational integration were not as advanced as with LA1. The CEO explained the effective integration of social workers from LA1 into the CMHTs as arising from a long history of collaboration between the two organisations.[66] (A study of prison rehabilitation programmes (Lin, 2000) found that historical relationships significantly influenced shared perceptions and collaborative efforts amongst implementers). Nevertheless, she commented that even with this authority it took a year to agree joint working.

It appears therefore that the policy of joint working with social services was not a settled matter across the board. A number of Trust managers seemed to divide what might be termed strategic questions of joint working from questions of joint working at practice level when assessing the policy (See Box 10.7). The CD did not see joint working as a particular policy priority since social workers from LA1 were already

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[64] See Chapter 2, Section 2.4
[65] See Chapter 8, Section 8.1c
[66] This comment resonated with my own practice experience of working with social workers from LA1 when working as a staff nurse and then charge nurse in the Trust.

integrated with the CMHTs, whilst the CEO stated that she felt social workers now saw CMHTs as their point of operational allegiance.

> "And I think that the social workers whilst they are managed by social services see their point of allegiance as being the CMHTs. So they feel part of the crowd and agree with what the crowd is doing by and large. I don't think on the ground at that level there is too much friction"
>
> **Trust Chief Executive**
>
> " I know that because we have agreed documentation across 'LA1' and there was an attempt to get 'LA2' to sign up and the social services took umbridge saying, "You are not telling us what we have to do". So I think there are those tensions that have always existed. They will just play themselves out. I think that is a potential problem if it is not handled well."
>
> **Trust Contracts Manager**

Box 10.7
System interface with practitioner 'seepage'

Alternatively, the CM felt that whilst there were no problems at the practice level there was a lack of systems integration and standardisation at an institutional level, which he saw reflected in a power struggle between the respective management structures over the degree to which social workers should be subject to Trust management directives. He felt that this was acted out in such areas as agreeing standardised documentation.[67] However, it appears that from the perspective of the CEO this struggle was being won by the Trust on the ground, as social workers were transferring their personal and day-to-day working allegiance to the CMHTs.

OPM2 gave an example of the lack of systems integration between the Trust and local social services when she indicated that there had been no agreed communication structures and avenues between herself and her counter-part in LA2. Consequently she often forgot to inform her counterpart about service developments within the Trust.

Overall managers viewed joint working as not a major issue. Their view seemed to rely on a belief that since so many social workers were integrated into the CMHTs a natural process of 'seepage' would occur in which social workers would take on CMHT values

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[67] See Chapter 8, Section 8.1c

and ways of working that would inevitably lead them to develop an operational allegiance to the Trust (Sheppard, 1990; Hannigan, 1999).

However, this diverged from the perspective of one junior manager -the CM- who perceived a more fractious and difficult relationship, something that the Government acknowledged was a problem in a 1997 Green Paper (Department of Health, 1997). If one looks at his particular comments (See Box 10.7), one sees, however, that even he appeared to believe that a joint working arrangement would inevitably develop in which, by implication, the Trust would become the dominant managerial partner.

10.2(i) Resource constraints as policy milieu

Bearing in mind the central Government requirement of District Health Authorities to make cost savings at this time and the various responses of the local DHA commissioners and Trust management to this policy pressure,[68] as an issue of local policy, resource allocation underpinning the internal market did not appear to be a significant issue in the critique of policy by most managers. There was some general comments that the internal market's emphasis on contracting for services and the associated bureaucracy encouraged a less collaborative environment. The CM mentioned the DHA's establishment of locality commissioning as an issue of concern; because of its unknown future impact on Trust relations with commissioners. The CD voiced brief criticism of GP fundholders, whom he saw as wasting resources.

Whilst this absence possibly reflected a more general acceptance of the premise of the separation of the commissioning function from provision of services, it may also have reflected managers' view that the issue of reductions in resources was a policy milieu rather than a policy issue. As such for most managers implementation of other policy requirements had to be accommodated within this service 'fact'.[69] Thus some managers spoke about the pressure to contain and reduce resource expenditure in terms of a *fait accompli* (See Box 10.8).

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[68] See Chapter 8, Section 8.3
[69] See Chapter 5, Section 5.5; Box 10.9a and quote from the ADNS in Box 10.9b for examples

"Well, em, they the purchasers probably are finding it harder than we are in the sense that we are probably a bit more hard nosed about it, em, the purchasers have been committed to mental health for years and when the Trust comes along and says 'well, actually, we think that you are saying, you have spent five years of planning and it has only been open for two years iand it is something we don't need', it is quite difficult"

Trust Deputy Chief Executive

"So that is the sort of MDO (Mentally Disordered Offenders) issue and of course there is no additional funding coming through the system in order to fund that, although we did recently gets an additional 850 thousand out of this recent priority fund-raising exercise that came through."

District Health Authority Commissioner 1

Box 10.8
Resource *fait accompli*

This more 'fatalistic' attitude appears to contrast with criticism of the central Government funding formula in the local 'Joint Strategy Plan'.[70] This criticism, however, was confined to one small paragraph and the overall tone of this document was not critical of resource policy, but emphasised the importance of working within resources.

The DCEO stated that Trust managers tended to be proactive in their approach to reorganising services in response to reductions in resources. He perceived, however, a difference between the affective response of the DHA Commissioners and the Trust managers towards such adjustments (See Box 10.8). The interviews with both DHA Commissioners indicated that they were not unwilling to see services reconfigured or reduced in the face of such pressures, however they acknowledged the Trust's proactivity in this area. Thus the CEO complained about the difficulties caused to planning because of the timing of information given by the DHA Commissioners on the level of resource available to the Trust, rather than the cut in resources *per se*.

The comparatively tardy response of the DHA commissioners might reflect an emotional investment on their part in relation to services. The DHA Director of Commissioning had previously been the General Manager of the mental health service. The commissioners were also a smaller group of managers compared to the more

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[70] See Chapter 8, Section 8.1a

diffuse Trust structure and therefore more personally involved in the formulation and overseeing of strategy implementation. Spillane *et al.*, (2002) point out that implementers are often reluctant to change or give up a long-held perspective for another when the change is the result of external pressures.

> "I mean we have had a line recently that "do not talk Trust mergers" from the Department of Health, not before the election anyway. And if you are going to, then it must be consultation in the summer prior to the financial year in which you want to do it. Now we could not and providers could not get their act together for this summer, so we are talking 1999 before we would ever have a merger. So maybe that is convenient."
>
> **District Health Authority Commissioner 1**

Box 10.9
Issues of process not policy

A complimentary explanation for this reluctance may have been a consciousness not to create local political controversies that could lead to national political problems at a time when a General Election was imminent (See Box 10.9). However, as a number of comments made by senior managers imply the central policy signal issued in relation to resource cuts was one in which process was the issue not the policy *per se*.

> Q: "In terms of your relationship with central government how conscious are you of trying meeting policy or managing this crisis in spending for the next few months?"
>
> "Yes. I must be careful here, I suppose, because I am a civil servant direct to the regional office, direct to the Secretary of State (laughs)."
>
> **District Health Authority Commissioner 1**
>
> "Often you carry the can in my position for a mixture of managerial and professional reasons and you can argue about individual cases how fair or otherwise it was. Life is not fair and often a person in my position might carry the can for essentially political reasons, in that somebody has to."
>
> **Trust Chief Executive**

Box 10.10
Consciousness of political accountability

As indicated in Section 10.2(c), there was a consciousness of the political sensitivity surrounding mental health. It would appear that for some this awareness also heightened their consciousness of their political accountability. Thus DHAC1 made a direct reference to the need to be careful in how things were phrased in answering my questions about resource policy because of his political accountability. The CEO made a

less direct reference when discussing the political pressures upon her in running the Trust (See Box 10.10).

There were two managers who voiced some criticism of Government policy on the resourcing of mental health services as it impacted on the local context (GPFH and ADNS). Both criticisms focused on the same issue – that services were required to meet needs for which they had not been resourced - in these cases the management of SMI and implementation of CPA.

It is interesting to note that both managers were clinical operatives. Thus the GP fundholder had a responsibility not only to purchase services but also managed patient care directly, thereby exposing him to the impact of resource policies at *street level*; experience which may have affected his opinion on this compared to managers who had no such contact.

Secondly, because of his position as a GP fundholder he may have felt generally free of the bureaucratic structure of the NHS, which in turn may have given him a sense of independence from political lines of accountability that managers, particularly those in the DHA, may not have had. Indeed, it is striking that despite the policy rhetoric surrounding the independence that the internal market conferred on 'purchasers' and 'providers' in the NHS, within mental health services such a sense of independence amongst some managers seems to have been considerably qualified by a consciousness of being answerable to a 'political' rather than a 'market' agenda.

In the case of the ADNS her primary responsibility within the Trust was to oversee professional standards within nursing through the formulation and dissemination of clinical practice policies. Thus within her management remit there was a strong emphasis on professional standards rather than a general management agenda. Her criticism of the resources allocated as opposed to required needs to be seen in this light; that is that she was more likely to be critical of a policy which she felt might compromise professional standards since this was something for which she carried a defined responsibility. Nevertheless, she displayed a policy fatalism also displayed by

other managers (See Boxes 10.8 and 10.9) in an acceptance that CPA had to be implemented despite her concerns that a lack of extra resources to implement it meant professional standards would be compromised.

There are displayed within these managers' perspectives on resource policy two inter-related *situated* perspectives. The first is that this is an established reality of the long-term service context; the second is that the policy issue in relation to resources is a process one - that is how one implements policy within such resource constraints. Even where criticism of the general resource policy orientation was voiced, the latter perspective was accepted as the dominant problem to be addressed. Indeed, one might argue that this *situated* perspective was the lens through which many policies were viewed. Thus issues surrounding authority in the CMHT, joint working, the future role of primary care and contradictions in policy could be seen as situated within an issue of control and deployment of resources to achieve implementation.

10.3 Conclusion - managers' policy perspectives

Overall, one might argue that policy that was seen as providing clarity of authority/ accountability or enhanced delivery of services was seen as positive. However, many managers' views on policy were tempered by a need to manage uncertainty in relation to the operational present and future. For example, disquiet about lack of information on resource constraints; the emphasis on SMI as opposed to non-SMI needs; the power of the GP fundholder to demand that their needs be met and the future structural relationship with primary care.

Policy was negatively judged where it was seen as causing intra-organisational difficulties or as unsympathetic to the particular issues associated with mental health. This was particularly in the case of the Trust when this was related to unduly prescriptive guidelines and requirements vis-à-vis Trust autonomy. One could also argue that in this regard the situated identities of individual managers could affect perspectives, sometimes leading to intra-personal conflict.

Bardach's (1977) conception of implementation as a *game* provides a helpful 'lense' through which one might understand this *situated* perspective of managers. He argues that agents utilise persuasion, bargaining and manoeuvres under conditions of uncertainty (which was certainly a perception of the policy environment amongst a number of these managers) as a means to expand their control over the implementation process. In this way they reduce their vulnerability and acquire a greater stake in the determination of implementation.

We may see this reflected in the articulated perspectives in two areas. Firstly, joint working, where Trust managers relied on day to day working in CMHTs as a surreptitious way to incorporate social workers into the management structure of the Trust rather than through a direct negotiation on this issue with the management of the local social services. They thereby reduced power struggles over personnel management to ones on standardisation of inter-organisational administrative practice, such as common documenting systems.

Secondly, the reconfiguration of clinical team leadership, which served to reduce uncertainty over consultants' attitudes towards management and provide a more accountable structure for implementation. This was achieved by agreeing to cede to consultants greater influence and authority over key areas of implementation.

With regard to this last point Bressers *et al*. (2000) state that implementers are usually in a dependency relationship in which the power balance can move from dominance to equilibrium and from strictness of implementation to mutual co-operation. It therefore seems appropriate to examine how inter-relationships amongst managers affected communication of policy. This will be addressed in the following Chapter.

CHAPTER ELEVEN

Managers' Sense Making and Implementation Relationships: Information, Implementation Heuristics And Policy Resistance

11.0 Introduction

This Chapter describes and analyses managers' views on the process of implementation. It examines the framework they seemed to employ to make sense of policy and which influenced their approach to its implementation.

Section 11.1 describes the exchange and nature of information as an important influence in the implementation process, whilst section 11.2 presents data on the nature and level of implementation resistance which managers either identified as problematic or engaged in themselves. Section 11.3 identifies the heuristics that managers appeared to utilise when discussing policy. Use of these heuristics was dependent upon the policy issue or audience. Section 11.4 examines the degree to which the identified issues in this and the previous Chapter were reflected in the group interview held with managers from outside of the case site. Finally Section 11.5 concludes that managers' policy judgements were predicated on an interaction of their heuristic frames of reference with intra- and inter- affective factors and the degree to which implementation was projected to differing audiences.

11.1 Information relationships

The level of exchange and nature of information is recognised as an important determinant in the implementation process in terms of policy perceptions and effects on implementers' behaviour (Knapp, 1995; Bressers *et al.*, 2000). Chapter 8, Section 8.5(b) highlighted the structural degree to which commissioners were dependent upon the Trust for information on implementation and outcome. Interviews with managers appear to indicate that the nature of this relationship was characterised by *informal personal*

contact, *information flow control* and *countervailing information control*. This Section examines these in detail.

11.1(a) Informal personal contact and blurred boundaries

Personal connections between commissioners and Trust management were emphasised by a number of managers when discussing the commissioning process, policy implementation and monitoring. For example, The Joint Mental Health Strategy[71] was, according to the DCEO, developed and written by just four people (The DHA Director of Commissioning, the DHA Director of Finance, the CEO, and the Director of LA1 social services department).

There was a high level of regular personal contact between senior members of the Trust management and DHA Commissioners. As previously mentioned the Director of Commissioning of the DHA had been the Trust' s General Manager during 1980s, whilst the current CEO had been the deputy General Manager at this time. Their relationship was described by the DCEO as, "paternalistic".

There was an impulse, apparently from the DHA commissioners, to emphasise informal personal contacts between just a few senior managers as a significant modus of communication about policy issues between the DHA and the Trust. According to the DCEO this was a source of tension between himself, the CEO and the DHA Director of Commissioning because of the potential for confused communication and the consequent tendency not to involve a range of significant actors.

However, whilst there were some tensions at the most senior levels, the degree of informal personal contact between the commissioners with the specific responsibility for mental health purchasing and Trust managers was seen by a number of informants (for example, the CM and DHAC1) as essential in smoothing relations between the two bodies. This level of informality did not exist between the DHA commissioners and the two other mental health trusts with which they worked.

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[71] See Chapter 8, Section 8.2

Though it might appear that such relations would encourage a non-critical stance in relation to the Trust, this was specifically denied by the CM and by DHAC1. There are hints, however, from some managers that the proximity of relationships did serve to undermine the central policy intention of creating a market boundary between purchaser and provider. For example, the use of the phrase 'managing concerns internally' by DHAC1 seemed to indicate such a blurring of boundaries, reinforced by a reluctance on the part of commissioners to tender for services or take rigorous action when they believed that commissioned priorities were not fully implemented, such as CPA (See Box 11.1).

"We have not got to the level, I mean, to tender for any service is an indictment really of your concerns as a purchaser in that trust or provider. So we have been reluctant to do that, I think, I know they have done it in other areas and you know that has been problematic. We have not really those big issues. We have had concerns but we have managed them internally and we have had to address those at a slower rate then we would have done."

DHA Commissioner 1

'When I asked her about the degree to which she felt that the contract was carried out she replied that they had little confidence that what they commissioned is being carried out. She said that there was a joint forum for the review of the performance of the contracted services between themselves and the Trust made up of the two commissioners, trust managers and clinicians, mostly it appears consultant psychiatrists She told me that that Professor X was a noticeably strong force within this group in determining its direction'

I've been surprised by how informal and unscientific the setting and monitoring of contracts is and how apparently powerless the commissioners appear to be once the contract is in place

Reflection notes from interview with DHA Commissioner 2

"I mean the other issue is for example that we have held a lot of power because maybe, and it is probably the same with other purchasers, you can bamboozle them with clinical jargon so well, 'we can't do this because we know from a scientific study that suicide is very prevalent amongst middle aged schizophrenics.' So I don't know. It is a very difficult one to answer. I am stuck on that."

Trust Contracts Manager

Box 11.1
Proximity blurring of boundaries

Commissioners also appeared to be intimidated by the proximity of the clinical expertise that could be deployed by the Trust and indeed upon which the commissioners were reliant when developing their own long-term purchasing strategies. The use of such expertise seems to have been a conscious ploy on the part of the Trust in their

negotiations with the commissioners so as to control the commissioning agenda (See Box 11.1).

Generally, whilst managers characterised relationships as harmonious it is notable that when issues of behavioural risk were involved some managers described the relationship as assuming a formal and interrogatory tone that was missing in other circumstances. This was also the case when, in such circumstances, the relationship was under external observation (See Box 11.2).

> "The main disadvantage is always the problem of having an informal relationship that is warm and hearty is that it can be too cosy. It has the potential for that, but I don't think, I think what you actually need is the broader structure that tests out how effective the relationship is. For example, and it depends on the contract, I'm involved in the complaints monitoring group and we have the LA1 CHC sitting in on that and the Health Authority and the users sitting in on it and I think we have had some very challenging times. Something came up recently about serious untoward incidents and the Health Authority were 'banging the drum', saying since there were a couple of complaints that should have been dealt with as serious untoward incidents and weren't. What are your reporting mechanisms? And you should be telling us."
>
> **Trust Contracts Manager**

Box 11.2
The effect of the interaction of 'risk' and external observation on DHA and Trust management relations

Similar informal relationships were mentioned by a number of managers with regard GP fundholders. Thus the DCEO specifically stated that the Trust played on the collegial relationships of doctors to manage their relations with GPs in part, it was implied, to control the demands placed on the Trust by them.

The degree to which this strategy was successful at the personal level can be gauged by the comments made by the GPFH on his relationship with the local consultant psychiatrist. His critical faculties and purchasing decisions appear to have been affected by her talking to him about her clinical issues and problems. Indeed, it would appear that there was a remarkable degree of trust in the information that he received through the consultant.

11.1(b) 'Trust' and information filtering

The Trust was required to meet and provide a range of information on various priorities set by commissioners.[72] Information typologies in this context can be characterised as firstly policy goal information - that is communicating policy requirements and intentions to and between management structures. In this case, other than Government issued guidelines, the primary medium through which this took place was DHA and GP fundholder issued commissioning intentions, a contract and the list of DHA core quality standards.[73]

The second type, performance information, that is implementation reporting and monitoring, was through informal dialogue and formal quarterly reports.[74] As discussed in Chapters 8 and 9, both groups of commissioners - the DHA and GP fund holders - were reliant on Trust management to provide them with information on the progression of contracts and meeting targets, rather than possessing an independent means of verification (though perhaps in the case of GP fundholders they had the direct reports of their patients on their experience of Trust contracted services).

Q: How confident are you that things that you Commission are met at the practice level?

"In overall terms and at macro level and in terms of changes of direction quite confident and the providers are demonstrating it as well, which is reassuring, aiding our confidence I suppose."

"In terms of the CPA and adherence to the basic elements-no. The implementation of the practice, that sort of real front end stuff no. …"

"But in overall terms I think yes. I think if there was a crisis as far as I can, I mean it is very difficult. Yes as far as I can, I am able to assess it and I think that you develop that in terms of a relationship that I would feel, you know, that's certainly the people that I have worked with would sort things out and would, yeah, address issues and would, there wouldn't be bad practice."

DHA Commissioner 1

Box 11.3
'Trust' through familiarity, 'openness' and 'sufficiency'

DHAC1 felt that commissioned systems such as CPA were implemented at a corporate level. He was less confident about quality and whether these systems were actually used

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[72] See Chapter 8, Section 8.5(b) and Chapter 9, Section 9.6,
[73] See Chapter 9, Section 9.6
[74] See Chapter 8, Section 8.5b

by clinicians in practice (See Box 11.3). However, he seemed remarkably sanguine about this. His attitude might be explained within the context of his remarks on familiarity with managers, reassured by the apparent openness of the Trust management with the commissioners on their failings. It would appear therefore that as long as the organisational level of commissioned policy appeared to be implemented, this commissioner trusted that lower level implementation would eventually take place because managers reassured him that it would.

An indication of the Trust's control of information was the degree to which the Trust managers could 'filter' and control information in relation to Commissioner demands. Thus the CM described how the Trust could use clinical expertise to obfuscate and decide either to supply or deny information to commissioners (See Boxes 11.1 and 11.4).

> "You know we talk contract negotiation meetings about all these numbers but how wrong they might be, that is being a bit too negative but their saying well your not responding to our core information requirements and you might say, the power is there because they are demanding stuff but in a way the power is with us because we are not supplying, but we are moving them. It does shift. I think it depends what the issue is we are talking about."
>
> **Trust Contracts Manager**

Box 11.4
Information control

It appears both from the comments of the CM, and other respondents that the Trust consciously exploited this position of information dependency[75] through the use of two mechanisms – reliance of commissioners on the professional expertise and status of certain clinicians employed within the Trust to control information relations with commissioners and DHA commissioners' 'trust' that information exchanged was comprehensive and true.

The second area of information dependency was the internal information flow between Trust managers and clinicians. It appears that in this relationship management engaged in an information filtering process, aided by a range of communication avenues (See

[75] See also Chapter 10, Section 10.2b

Table 11.1), though primarily relying on direct contact with clinicians within a context of persuasiveness rather than directives; whereby core contract messages rather than the totality were communicated. These usually supplemented standard messages about the need to operate within budget and were generally communicated verbally by the respective operational managers to teams and through meetings between the CD and the CMHT leaders rather than in written format.

Communication avenues between managers and clinicians

- Memos to CMHT team leader
- Communicating requirements through service managers and clinical directors through meetings with CMHT team leaders and CMHTs
- Monthly report on activity and income to the executive management team
- Quarterly report on core quality standards
- Internal trust report on key result areas
- Monthly meeting between CD and Heads of Profession and Consultants
- Quarterly meeting between Executive Directors and the Clinical

Information returns and projected messages to ensure implementation compliance

- Monthly activity returns;
- Training staff to use new documentation;
- Telling staff that they have to follow policy because it is enshrined in legislation;
- Being required to make an application to fund certain treatments;
- Standardising operational structures between CMHTS;
- Requiring clinicians to account for the construction of their caseload;
- Changing practice policy guidance;
- Threat of disciplinary action

Table 11.1
Trust management communication avenues and information requirements

CPA and SMI meant that to some degree the Trust management had to ensure that clinical discretion was monitored formally, for example through monthly activity returns. This was to demonstrate compliance through a combination of information returns, communication of expectations and a milieu of implied consequence in relation to disciplinary action for non-compliance (See Table 11.1).

It is noticeable that opportunities for clinicians to communicate their views on policy to senior management as opposed to their performance in relation to these messages were limited.[76] Some managers expressed concerns about the lack of involvement of clinicians in policy development and implementation. DHAC1 saw a lack of a wider dialogue with lower level clinicians as problematic, but said he could see no way of solving the problem. The ADNS discussed the failure of the Trust to consult widely with CMHTs before and during the contracting process. The DCEO expressed concern at a lack of a wider consultation, though with the Trust's consultant psychiatrists, rather than clinicians *per se*. He felt lack of consultation sometimes meant that issues of practice were not considered within strategic planning. The latter two blamed this lack of involvement for what they saw as clinicians' alienation from the implementation process and a shared view as to what was important operationally.

11.1(c) Countervailing information power

The need to supply the Trust with information in terms of clinical activity and meeting quality, for example Patient Charter standards was seen as a source of tension between managers and clinicians. The ADNS said that there was an over emphasis on monitoring systems and requirements on clinicians to report on the minutiae of activity in some instances, without an assessment of the reasons for reporting on such activity. The CD stated that he felt that a lack of clinical background amongst some of those requesting information (for example the DHA) helped explain why so much was asked for and why so much appeared clinically irrelevant.

Whilst the Trust management required clinical staff to make information returns on their activity in relation to key implementation areas, it is clear from the comments of some managers that this did not always occur. Thus the ADNS pointed out that staff often did not fill in activity returns. The CNA stated that CPA record keeping was patchy because clinicians did not see much point in recording data they had already entered onto the nursing care plan. The CM also stated that he had doubts about the veracity of the practice returns. These comments highlight a relationship of the information

[76] See for example, Chapter 9, Section 9.2b

dependency of managers upon clinicians with an inability to improve staff's compliance with information returns beyond process.

The control of information between the Trust and the commissioners seemed primarily to lie with the Trust. Alternatively, as the need for financial savings and the purchasing response of the DHA indicates[77] a countervailing power lay in the commissioners' control of the purchasing budget, the purchasing intentions document published by both the DHA and GP fundholders and the information on performance required as set out in the Core Quality Standards.[78] This countervailing power does seem to have caused some resentment on the part of Trust managers.[79] The CM felt that the DHA was over-bureaucratic in terms of the core quality standards with too many targets that were, in his view, in parts difficult to understand. This dislike of what was seen as DHA information bureaucracy was captured by the comments of the DCEO who stated that for the DHA it seemed that being seen to engage in processes was more important than the quality of the content provided.

11.1(d) Concluding comments – information as an exemplar of 'embedded' relationships

Mechanic (1998) identifies 'trust' between parties as an important factor in the implementation process.[80] Trust in information, the communication process and implementation appear connected. Structural processes of communication as described in Chapters 8 and 9 seemed less important in this relationship compared to personal contacts, established through working familiarity and/or collegial identification. Thus all parties (Commissioners and Trust managers and Trust managers and clinicians) emphasised personal connectedness as the principal means of communication.

One can describe the nature of the relationship between commissioners and the Trust as 'embedded'.[81] Commissioners, particularly DHA commissioners, at times seemed to

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[77] See Chapter 8, Section 8.3
[78] See Chapter 8, Section 8.5b
[79] For example see the comments of the CEO, Chapter 8, Section 8.5
[80] See Chapter 2, Section 2.6f
[81] Embed - to fix or become fixed firmly and deeply in a solid mass, to surround closely (Collins Concise Dictionary, 1999). Use of the term 'embedded' replaced an earlier term of 'enmeshed' following my awareness of criticism that reporters who were 'embedded' with US and UK military units in the recent

place a high level of trust in the implementation information that the Trust provided based on the value they vested in their personal working relationships with Trust managers. Consequently, the 'tension of interest' that the policy of the internal market had been intended to create[82] changed at local level to a 'mutuality of interest'. This embedded relationship could be consciously exploited by Trust managers at times through information filtering, exploiting the information dependency of commissioners, utilising personal contact to deflect demand and intimidating commissioners with the status of the expertise available to the Trust and its proximity to commissioners.

There are three caveats to this conception of 'embedded' relations that need to be addressed. First it is notable that the effect of meetings in which either organisations external to this 'embedded' relationship were present or in which questions of 'user risk' were involved was to discourage 'mutuality' and encourage a somewhat more oppositional dialogue. Baum (1984) points to the importance of the threat of public scrutiny in its affect on implementation compliance. Thus the general political climate at this time[83] and the particular political focus on users' behaviour in the community may account for this more 'antagonistic' aspect to relations.

Secondly, the relationship with the two other Trusts was not 'embedded', but appeared, from information supplied by the CEO and DHAC1, to be often tense.[84] The reasons for this may be inter-related. The first was that the Commissioners had not traditionally worked with the two other trusts since they had been 'inherited' from a previous merger. The second was the financial comparative scrutiny that the trusts were under and, in particular, the disadvantage this placed the two smaller trusts compared to the larger Trust in terms of economy of scale. Both Lin (200) and Arentsen and Bressers (1992) point out previous encounters and history between policy actors are a significant determinant of good/poor relationships in the policy process. Thus it would appear in

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second Gulf War compromised their status as independent observers and commentators on the war. This concept seemed to me to better capture the conclusions I had reached following analysis of the data on communication of information and what it had to say about the nature of the implementation relationship between commissioners and Trust management.

[82] See Chapter 2, Section 2.1a

[83] See for example Chapter 10, Box 10.9

[84] See for example, Chapter 8, Section 8.3

this context that the Trust was historically advantaged compared to the other two trusts in its relations with Commissioners.

Finally, the power relationship between Trust management and CMHTs in relation to information demonstrates the limit of relying on an 'embedded' approach to control the agenda and process of implementation. Whilst managers attempted to rely on informal contact with CMHTs to secure information compliance it appears to have failed because clinicians distrusted managers' agenda based upon a perception of information requests and credibility.

11.2 'Affect' and implementation – 'collusive ambivalence'

As discussed in Chapter 4, 'affective' responses on the part of actors to policy and the process of implementation is recognised as a significant but under-investigated issue within implementation research in terms of impact on implementers' interpretation of policy (Moesinger, 2000; Spillane *et al.*, 2002). Both Fisher (1998) and Lipsky (1980) highlight the importance of affect in creating tensions between managers and 'street-level' workers, particularly within an environment of resource reductions.[85] This section therefore describes the reported affective aspect of policy implementation by examining what managers perceived as sources of tension between themselves and clinicians, their affective responses to this and the relationship between affect and ensuring policy compliance.

11.2(a) Managers' perception of tensions with CMHTs

Five principal areas were identified by some managers as sources of tension between themselves and CMHTs (See Table 11.2). A number of respondents spoke about clinicians' resentment or discomfort with a perceived management interference with their discretion, particularly if it was perceived as a means of saving money. However, the CD said that the only interference with his clinical discretion was that he was required to justify his prescription of respiridone.[86] The ADNS and the CNA stated that issues of autonomy and discretion were also a source of conflict <u>within</u> CMHTs,

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[85] See Chapter 5, Sections 5.1, 5.2 c and d
[86] See Chapter 4, Section 4.4;

particularly with regard to a fear of the power of the clinical team leader to interfere with autonomy of other non-medical clinicians.[87]

Identified tensions	Constraining autonomy and discretion	Information requirements	Increasing caseloads	Cutting services	Managers lack clinical credibility
Sample unit					
ADNS	1	1	1	1	0
CD	1	1	1	1	1
CEO	1	1	1	0	0
CM	0	1	0	1	0
CNA	1	0	1	1	0
DCEO	1	1	0	0	0
OPM1	1	1	1	1	1
OPM2	1	1	1	1	0

Table 11.2
Perceived sources of tension with CMHTs

A few managers also identified a combination of an increased workload and a belief that Trust management saw the needs of GP fundholders as a priority (something managers denied), whilst still expecting teams to focus on SMI as a source of tension. This was closely linked to perceptions that CMHTs resented the demands made upon them to provide a range of information to the Trust and GPs, much of which, according to some managers, they saw as irrelevant or required by people who lacked clinical credibility. This sense of what the CEO referred to as 'siege' could be further exacerbated by resource cuts either in terms of budget or in terms of an inability to recruit replacement personnel when a CMHT member left.

11.2(b) *Unjustly ' scapegoated'*[88]

The ADNS and the CNA noted how clinicians' general criticisms of policy were mediated through a 'blame management' attitude for its implementation. Some managers said they felt that clinicians saw them as the author of central government and DHA policies rather than as a policy conduit. For example, the CM felt that clinicians

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[87] See Chapter 10, Section 10.2g
[88] Scapegoat 'a person made to bear the blame for others' Collins (1999).

reconciled the demands placed upon them by the external environment (the political context and demands of stakeholders) by blaming management for imposing practice change. In this sense some managers appeared to feel they were the victims of a policy reactive displacement on the part of clinicians.

OPM1 felt that clinicians did not understand her role and that she and they in fact had a shared agenda. OPM2 explained that this hostility on the part of clinicians towards managers arose in part because in the past there had been some managers appointed to the Trust who had met a managerial stereotype held by clinicians.

Some managers empathised with clinicians feelings about some service closures in relation to the potential such cuts had in increasing the complexity and size of the clinical workload and having to adjust to the notion that people in distress may not have immediate access to help but might have to go on a waiting list. OPM1 stated that one of the ways of diffusing the tension between clinicians and managers over such cuts was by admitting that they were financially rather than clinically driven (of course this implies that managers had not been honest with clinicians over such issues in the past).

11.2(c) 'Defensiveness'

A number of respondents spoke about a general culture of blame that permeated all levels of the NHS. The ADNS conceptualised it as 'buck passing' in which people were reluctant to take responsibility. The CD seemed to support this view, speaking of a culture of defensive practice. The interaction of individual fear arising from a perceived blame culture, 'buck passing' and defensiveness may be seen in OPM2's description of the anxiety she found in one CMHT in rejecting GP referrals because of the perception that the Trust prioritised GP fundholders' needs. OPM2's response was to advise the CMHT that this was not so, but that clinical decisions of acceptance or rejection in relation to GP referrals was their responsibility.

11.2(d) Rivalry and 'disempowerment'

The CNA indicated that she had an antagonistic relationship with the operational managers of CMHTs because they often over-ruled her professional advice. Both

OPM1 and OPM2 expressed frustration in their role in relation to social workers working within CMHTs since they did not have authority over them when attempting to get them to follow Trust policy, but had to rely on persuasion and regular liaison with the social services line manager who could refuse to support them.

> "So I think that we, in terms of influencing the practitioners, they are influenced but it is more that they come on board because they are worried about being disciplined or losing their jobs at the end of the day and not because they can see the benefits to patient care."
>
> **Trust Assistant Director of Nursing Services**

Box 11.5
Compliance through insecurity

11.2(e) Managers' toleration of implementation resistance

The primary means upon which Trust management appeared to rely to ensure compliance amongst clinicians was a climate of employment insecurity which, the ADNS felt, was prevalent within the NHS. She felt that staff within the Trust had interpreted the number of management re-organisations, the service reconfigurations and the general contractual environment as a signs of this insecurity and a potential threat to themselves. In this context a number of managers spoke about the threat of disciplinary action, as a means of communicating with clinicians what might happen should one engage in covert implementation defiance (See Box 11.5).

However, the degree to which such threat could be seen as successful is questionable since managers described a variety of indirect and direct ways in which clinicians appeared to either defy or only partially implement policy requirements (See Table 11.3). In particular most managers described how clinicians either did not record data or only partially complied with data recording procedures.

Non-compliance strategies	Not record data	Emphasis on working within professional boundaries	Not attending meetings	Voicing negative views	Using clinical autonomy	Not volunteering information	Not volunteer to train	Following guidance to the letter
Sample unit								
ADNS	1	1	1	1	1	1	0	0
CD	1	0	0	0	1	0	0	0
CEO	1	0	0	0	0	0	0	0
CM	1	0	0	0	1	0	0	0
CNA	1	0	0	1	0	0	1	1
DCEO	0	0	0	1	1	0	0	0
OPM1	1	0	0	1	0	1	0	0
OPM2	1	0	1	0	0	0	0	0

Table 11.3
Managers' descriptions of clinician s policy non-compliance strategies (1= coded; 0= uncoded)

Some managers speculated on the reasons why clinicians disrupted implementation. The ADNS, amongst others, said lack of compliance occurred if clinicians perceived policy as interfering with practice, imposed without regard to their views or as an implicit or overt criticism of their practice. The CM, amongst others, pointed out that clinicians were tardy or did not implement policy when they felt it was not clinically relevant.

The DCEO believed that clinicians' criticisms of policy interpretation and implementation were sometimes valid. This provides an indication as to why some managers appeared to tolerate a level of partial non-compliance, for example incomplete information returns, – namely that a number of managers had sympathy with some staff attitudes towards what they were asked to implement. Staff resistance to policy could also suit the Trust management agenda. For example, citing clinical judgement as a reason for non-implementation of policy with which Trust managers did not agree (See Box 11.1 for example). One might describe some of these management responses to lack of implementation by clinicians as a form of *collusive ambivalence*.

> "So what we do is out of kilter with the Patient's Charter and our argument is they have got it wrong not us. So that is when problems occur and in trying to monitor those it is taking a long time for the services to accept that they should be monitoring something that is not meaningful."
>
> **Trust Contracts Manager**
>
> "Yeah, em, but then I have to put on a 'well you have to do it anyway, I know you don't want to, I know it didn't help, but you have to', and that I mean that again is a lot of pressure, when you yourself can see em, that a. it doesn't help or benefit anybody, least of all the patients, collecting all this information, but you are required to do it and you are told to do it and you then have to go and tell the teams"
>
> **Trust Operational Manager 1**

Box 11.6
Examples of Collusive Ambivalence

11.2(f) 'Collusive ambivalence'[89]

There were a number of managers who demonstrated a degree of ambivalence towards policy (See Box 11.6). The ADNS stated that she was uncomfortable with the way policy was generally imposed 'top down', with a consequent lack of ownership on the part of those affected; yet at the same time she conceptualised her role as interpreting

[89] 'Collusive' secret agreement between opponents; 'Ambivalence' coexistence of two opposed or conflicting emotions (Collins, 1999)

such policy for clinicians and ensuring their compliance. The CM indicated an ambivalent attitude towards the Patient's Charter standards and, in particular. empathised with the perspective of clinicians who saw the collection of such data as irrelevant to practice issues. OPM2 reiterated this view. She went on to describe how she 'colluded'[90] with CMHTs to see how they could fit their returns into the criteria even though they did not necessarily reflect reality of practice.

11.2(g) Concluding comments – 'isolated implementing actors'

Some managers perceived both themselves and clinicians as operating within a contingent and insecure policy climate within the NHS.[91] It appears that a number of managers did not like this sense of being seen as both author and enforcer of policy, particularly in circumstances where they felt powerless in both areas. In this sense they could be said to be 'isolated implementing actors' (See Box 11.7) rather than 'agents' since they were held responsible for implementation from both above and below, for interpreting as opposed to authoring policies that they perceived as problematic rather than helpful either to themselves or the service for which they were responsible.[92]

> "Yeah, it is trying to be the person, it is trying to be just that person that interprets policy into discussions about reality and practice and how it is going to happen and the Service Manager level is that person, that operationalising policies that come down from above really. You know, people say 'right, we are doing this', so you do it and then it is I have, you know, service managers have pressure from above, but also pressure from below about well, you know, you can't possible be asking us to do that, because it won't work."
>
> **Trust Operational Manager 1**

Box 11.7
Isolated implementers

11.3 Implementation heuristics

Spillane *et al.* (2002) and Zerubavel (1999) point to the importance of cognitive processes affecting actors' interpretation and judgement of policy. As discussed in Chapter 5, Section 5.1, Fisher's concept of implementing heuristics (cognitive rules of thumb) is significant because he argues these are what managers use in judging how to project policy to those affected in terms of admissibility and acceptability so as to

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[90] My word not hers.
[91] See for example, CEO comments, Chapter 10, Box 10.9b, ADNS, and Section 11.4d
[92] See also Chapter 10, Sections 10.2c and d

produce outcomes which managers find acceptable to themselves. This Section describes the four heuristics that appeared to be used by a number of the managers in this case study to interpret and implement policy (See Table 11.4).

Table 11.4 Implementation heuristics (1=coded; 0=uncoded)

11.4(a) '*Risk cognisance*'

Heuristic	Conduct	Defensive contingency	Capacity
Sub-unit of analysis			
ADNS	1	1	1
CD	0	1	1
CEO	1	1	0
CM	1	1	0
CNA	1	1	1
COMM1	1	1	0
DCEO	0	1	0
GPFH		1	
OPM1	0	1	1

11.4(b) *'criteria of virtue'*

Heuristic	Utility	Equity	Uniformity	Explicitness
Sample unit				
ADNS	1	0	0	1
CD	1	1	1	1
CEO	1	1	1	1
CM	1	1	1	1
CNA	1	1	1	1
COMM1	0	0	1	0
DCEO	1	1	1	1
GPFH	1	0	0	0
OPM1	1	1	1	1
OPM2	1	0	1	1

11.4(c) *'Discriminating'*

Heuristics	Rely on clinical autonomy	Adaptation	Selective focus	Processes
Sample unit				
ADNS	0	1	0	0
CD1	1	1	1	0
CEO1	0	1	1	0
CM1	0	1	1	0
CNA	0	0	1	0
COMM1	0	0	1	0
DCEO1	0	0	1	1
OPM1	1	1	1	0
OPM2	1	0	1	0

11.4(d) *'Stewarding resources'*

Heuristics	Prioritise in relation to capacity	Abhor waste	Need to conserve	Justify expenditure	Opportunity cost consciousness	Proactive management	Accountability
Sample unit							
ADNS	1	1	0	0	0	1	0
CD	1	1	0	1	1	1	0
CEO	1	1	1	1	0	1	1
CM	0	1	1	1	0	0	0
CNA	1	1	0	1	0	0	0
COMM1	1	0	1	1	1	1	0
DCEO	1	1	1	1	1	1	1
OPM1	1	1	0	0	1	1	0
OPM2	1	0	1	0	0	0	1

11.3(a) Risk cognisance

Risk is traditionally defined in terms of economic risk (loss) and behavioural risk (danger to self or others) (Adam and van Loom, 2001). As indicated in Chapters 1 and 2, a societal feature of 'risk' during the 1980s and 1990s was that it had to be managed and reduced (Crowe and Carlyle, 2003). A number of managers appeared to utilise these constructions of risk in their views of implementation monitoring and in particular how quickly a 'risk' issue was reported. Thus there was concern that clinical conduct needed to be monitored to ensure that managers were sufficiently alerted to practice mistakes. This was reflected by the comments of the CM and DHAC1 who emphasised the importance of being informed when a serious untoward incident took place. User 'risk' behaviour was seen as requiring responses so as to increase and maintain public confidence. Indeed, a striking feature about DHAC1's comments on this issue is the degree to which he was concerned that 'risk' issues did not become public and cause a political problem.

> "On a local level, em, there have been a number of localised policies that have been in place for a number of years affecting Community Nurses one of which was a sliding scale administration depot medication, which we have had to stop much to the angst of both the consultant team and the CPNs who thought they were being disempowered by it. But it was not legally nor professionally acceptable and it was felt more appropriate to stop it rather than discipline everybody for doing something which in fact some manager a few years ago said they should be doing."
>
> **Trust Chief Nurse Adviser**

Box 11.8
Defensive contingency

Issues of conduct were closely linked to a heuristic of 'defensive contingency' illustrated by an emphasis on the recording of information, specific situational policy guidance and an emphasis on safety as the rationale for increasing staffing levels. DHAC1 indicated how untoward incidents could be used at local level to put pressure on the Trust as a means of initiating changes that might otherwise be resisted. This contingency heuristic may also have been linked to a fear of the potential for litigation. For example, the ADNS spoke about an organisational fear of litigation as one of the prime reasons why data recording was so emphasised. The potential for litigation influenced, according to the CNA, changes in clinical practice with regard to staff using

previously acceptable professional judgement in the administration of a sliding scale of medication (See Box 11.8).

Some managers spoke about the capacity to accommodate risk as a point of reference for thinking about implementation. For example, OPM1 discussed her day-to-day considerations in relation to the CMHTs she managed in terms of risks involved in particular situations; who should be discharged from the in-patient units into the care of the CMHT in terms of the balance between discharging people at risk and the risk posed to Trust resources by keeping them within hospital and what level of caseload could be safely managed by the CMHT.

The CD, though also utilising a risk capacity heuristic, utilised it in terms of changing clinical practice away from defensiveness to one that encouraged a proactive management of user behaviour in relation to risk. He said that CMHTs had been organised in the Trust to encourage this more proactive stance.

Summary of exemplars of negative utility based judgements

1. The level of bureaucracy increases for no discernable return (ADNS; CD; CEO; GPFH; OPM1);
2. Some services no longer contribute to effective care or met current needs (CD, CNA; DCEO);
3. Policy prescription focuses on containment to the detriment of empowerment of patients (CEO, ADNS; OPM1);
4. Policy is over prescriptive denying flexibility of response (CEO, ADNS, DCEO; OPM1);
5. An over-emphasis on process rather than outcomes (CEO, CM);
6. Policy guidance is ambiguous or inappropriate for the needs of mental health practice (DCEO, OPM1)

Summary of exemplars of positive utility based judgements

1. Provides an opportunity to improve a service through gathering outcomes based evidence (CEO);
2. Appears relevant to need (CEO, CNA)

Table 11.5
'Criteria of virtue' influenced opinions on policy

11.3(b) 'Criterion of virtue' [93]

A 'criterion of virtue' drawing on principles of *utility*, *equity*, *uniformity* and *explicitness* was employed by many managers in their discussion of policy (See Table 11.5). *Utility*, that is how organisationally *useful* a policy was, was construed in terms of whether it improved service delivery or made life easier for those charged with implementation. Thus, for example the 1995 Mental Health Act's requirements on Supervised Discharge was judged as unhelpful in this context and therefore goes some way towards explaining why it was hardly used within the Trust.

Reference to concepts of *equity* and *uniformity* was shown principally in terms of a dislike of privileging individuals over groups and practice idiosyncrasy. The importance of standardisation within and between services was emphasised as an important principle that policy and its implementation needed to reinforce. In part to guarantee a degree of predictability/ stability within service relationships and delivery as means of facilitating long-term planning, but also to facilitate the internalisation of particular policies and implementation processes by clinicians. For example, the CD spoke about the need to articulate a trust wide service model, whilst the CEO talked of the need to regularise the operational arrangements of the CMHTs, for example uniformity of caseload size. One may also see this heuristic in operation in relation to the views expressed about clinical team leadership.[94]

Explicitness seemed to be articulated in two ways - accountability and structures. For example, the CEO said that accountability was about properly describing what one did. She differentiated between managerial accountability - that is how clinicians deal with the total caseload - and professional accountability - that is how a clinician deals with an individual patient. The CNA emphasised the importance of scrutiny of clinical practice; whilst the DCEO emphasised the importance of clarity of leadership structure in the CMHT so as to manage effectively the clinical resources. The importance of

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[93] I chose this descriptor as it involves a sense of a standard against which to judge and an admirable trait, thus encompassing both an assessment and principle that implies what is valuable/ of worth in a policy, structure or action in perceiving and doing. The concept of virtue is also associated with beneficence and utilitarianism, 'the greatest good for the greatest number' (Chisholm and Stewart, 1998) which I felt was one of the elements in this heuristic.

[94] See Chapter 10, Section 10.2g

explicitness to a number of managers maybe seen in the comments of OPM2 who emphasised the value of clear procedures and that an explicit articulation of clinical team leadership clarified her relations with the CMHTs.

There appeared to be a number of exceptions to the utilisation of the 'criterion of virtue', for example, the focus on only placing SMI on CPA. However, this may be explained heuristically in terms of the interaction of fair distribution in relation to need. Within a context of limited resources those with the most complex problems would need more help than those with less complex problems and both uniformity and explicitness would mean that this needed to be articulated, particularly to ensure need was accountably met. Thus the interaction of all four sub-heuristics of the 'criterion of virtue' in this regard leads to a justification on a focus on SMI. However, they also lead to some doubts, particularly with regard to fair distribution in relation to epidemiological distribution of need.[95]

11.3(c) Discriminating

A notable theme to emerge from the interviews with managers was the degree to which a number appeared to choose not to follow policy fully but to interpret what they saw as the key elements and to discard others. In this regard they appeared to follow a heuristic of what might be termed *discriminating* compliance. This discrimination could consist of a selective focus on policy implementation, for example, identifying policy elements which must be seen to be done and ignoring those which central policy appeared to place less emphasis upon, for example placing SMI on CPA rather than the original stated policy of all users.

There was also a reliance on clinical autonomy as a means of interpreting and modifying policy, for example having one patient on Supervised Discharge. Other examples were the local modification of CPA, and selective use of HoNOS, which was implemented locally on the basis of clinician views rather than in reference to central policy guidelines.[96]

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[95] See for example DCEO comments, Chapter 10, Box 10.5
[96] See Chapter 10, Section 10.2c

Connected to both these was adaptation of policy to suit local conditions. Thus for example the Trust setting their own standard and definition of SMI in the absence of a central government one, with regard to CMHT caseload size. This allowed the management to set these at a level they thought they could achieve, whilst providing evidence of their commitment to the central policy thrust.

11.3(d) Resource stewardship

The CEO when asked to describe her role talked of, "… ensuring the safe stewardship of the resources". A 'steward' is defined as 'a person who administers the property or finance of another'; it is also defined as 'a person who helps to supervise some event or proceedings in a official capacity' (Collins, 1999). Thus the word encompasses both a supervisory process and delegated control. The use of the word 'safe' in conjunction with the word 'stewardship' is interesting in that 'safe' encompasses concepts related to 'affording protection', 'securing from risk' and 'avoiding controversy' (Collins, 1999). There was thus encapsulated within the CEO's conception of her role a sense of caution and awareness of responsibility to others with regard the control and distribution of resources. This appears closely associated with ri*sk cognisance* (See Section 11.3a).

"…actually looking at the Trust actually examining whether we have the capacity to deliver what those particular people want and on occasions we have said we can't, we can't actually deliver that level of service, or that type of service and give them the reasons why."

Trust Assistant Director of Nursing Services

"Financial, financial is very important to the service. The service also runs within the financial constraints."

Trust Operational Manager 2

Box 11.9
Cautious resource management

This caution was reflected in the issues relating to resources that a number of managers described. For example, both the DCEO and OPM2 talked about commitment to stay within budget, whilst the ADNS described how the organisation would only do things that it was felt was within the capacity of existing resources (See Box 11.9).

The 'proactive' approach to resource management advocated by some managers primarily related to a need to contingency plan within an assumed context of resource

shortages so that the overall resource security of the Trust was not threatened. Therefore this heuristic was also closely related to 'capacity' - that is only providing what was affordable/ paid for.

There was a difference within the heuristic articulated by DHAC1, in relation to the responses of the DHA to central Government requirements for cost savings[97] and the CEO and DCEO, in that DHAC1 articulated a position that was reluctantly proactive in response to resource shortages,

> " Because we are forced to make some major changes in services. We didn't want to do it and we haven't had to because they (the 'Trust') have responded by being more sympathetic."

As the latter part of the quote indicates, the Commissioners appeared to rely on the Trust management's responsive service re-configurations of services to avoid making difficult decisions; perhaps both politically and affectively.

11.3(e) Concluding comments – audience, heuristic and implementation

The above heuristics differ from those identified by Fisher (1998) discussed in Chapter 5, Section 5.1 in that they are not solely concerned with the management and allocation of limited resources, but extend to a 'political' domain that incorporates other issues of mental health policy. Whilst the utilisation of these identified heuristics by managers, particularly those within the Trust, rested to some degree on policy projection for external and internal audiences, as Fisher (1998) argues the political nature of this projection was recognised through the control of information and the demonstration of a corporate level of implementation of policy in relation to political goals with regard community mental health policy (See Section 11.1(b) and fig. 11.1). Thus 'Risk cognisance' appears premised primarily in relation to external political, public and juridical audiences, but also internally through the monitoring and guidance of clinical activity in relation to user behaviour.

'Stewardship' also seemed to be determined through this dichotomy of audience. This was externally in terms of justifying services and their provision or closure to the public, and internally, in terms of proactive organisational restructuring.

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[97] See for example, Chapter 8, Section 8.3a

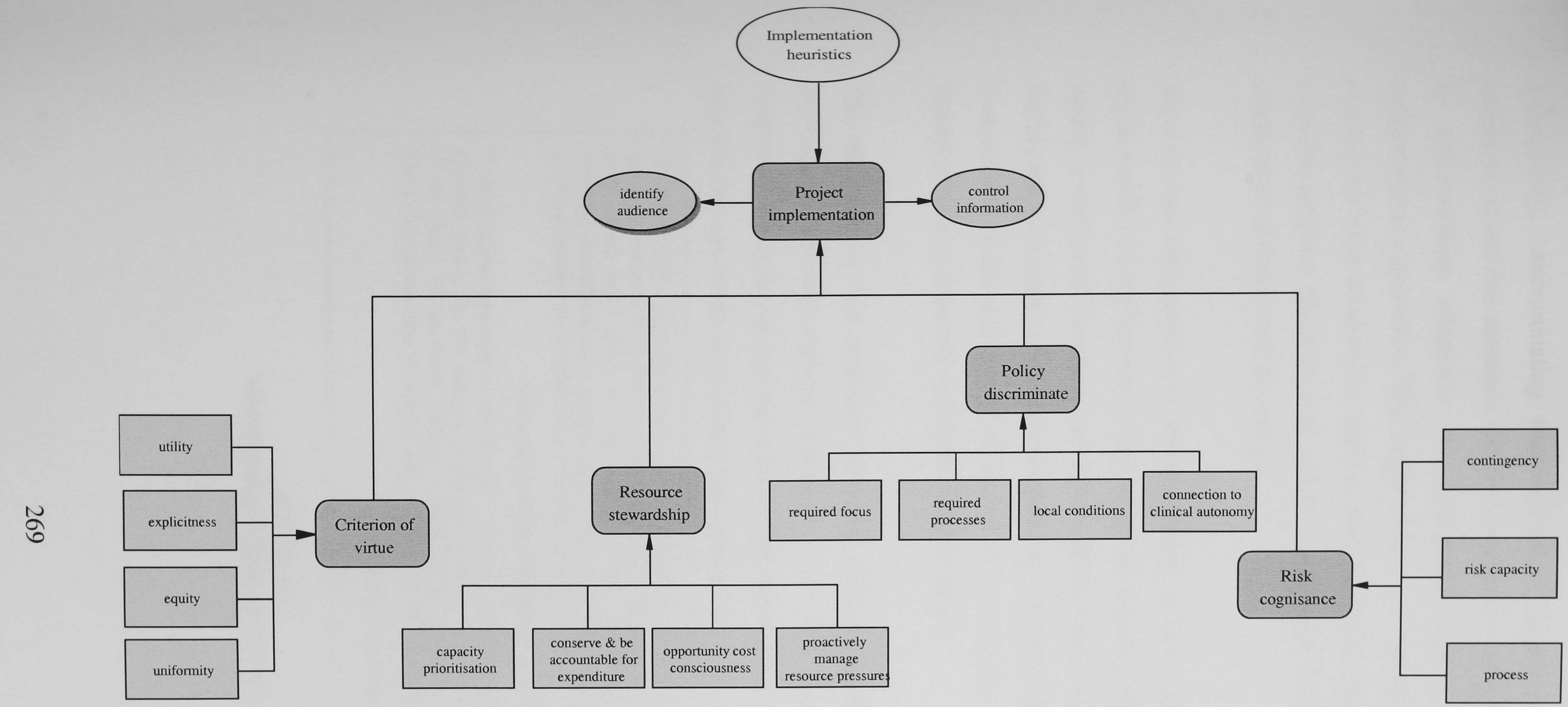

Figure 11.1

Audience and implementation heuristics

Alternatively, 'discriminating implementation' appeared primarily determined in relation to an external audience, that of Government and the DHA. The focus appeared on demonstrating allegiance to emphasised policy prescriptions rather than comprehensive compliance. This might be seen as connected to policy symbolism, that is policy not taken seriously by implementers *per se* but implemented in a token fashion for public purposes (Bressers *et al.*, 2000). An example in this case was the very limited employment of Supervised Discharge.

However, this interpretation of 'discriminating' as just involving the 'symbolic' would not be a sufficient explanation of the use of this heuristic. The heuristic as described and used by a number of managers also appears to have been to differentiate between policy that needed to be *seen* to be implemented by the external audience and an assessment of *acceptability* to this audience of the degree of implementation. Thus this heuristic goes beyond producing a merely symbolic implementation.

The one heuristic that appeared primarily utilised in relation to internal audiences, services and clinicians, was the 'criteria of virtue'. This was used primarily in relation to structuring and ordering internal relationships with policy. As such it was the primary heuristic through which most policy was interpreted.

"Probably public perceptions are more important than resource limits. For example last year I over spent by 800 thousand pounds in mental health and the rest of the trust baled us out and I didn't feel guilty about it and I didn't get sacked. We just kept exploring that and there is nothing like bringing the water to people's eyes if there is a serious incident up. It might be a different story this year."

General Manager Mental Health Adult Services

"I think public perceptions are crucial. I mean you only have to be there when an incident occurs like the one you mentioned earlier to see the wheels go, the press is on the phone, we are being rung up at home about, you know, and once you see all that go into action then you know how important public perceptions are"

Deputy Chief Nurse Adviser

Box 11.10

Maintaining public confidence

11.4 Group interview

The group interview was conducted after all management interviews had been completed and analysed. Interviewees were asked to discuss the same range of issues as the individual managers. Generally, issues and perspectives raised were similar to those raised by individual interviewees. Thus for example, national policy was discussed in terms of reinforcing and maintaining public confidence in mental health services, the contextual insecure atmosphere and the need to manage risks and resources (See Box 11.10).

There were two areas where the interaction amongst the group highlighted differences of emphasis in relation to those mentioned by individual interviewees. These were 'embedded relations' and the inter-relationship of 'discriminating' with 'risk cognisance'.

In the area of 'embedded relations' the group had little to say about their relationship with their local commissioners other than the confirmation of the heavy emphasis commissioners laid upon receiving performance information. Managers in this group explicitly identified their 'embedded' relationships with clinicians in terms of a need to retain goodwill to ensure effective implementation, whilst also highlighting a tension of trust in this relationship.

DCNA believed there was a tendency on the part of managers, particularly those from a clinical background, to identify with clinicians' needs as a result, sometimes laying them open to be consciously manipulated by clinicians. Alternatively, another manager pointed out that although this was a danger a clinical background could provide a manager with insight into management problems and alert them to when clinicians were attempting to manipulate them.

The Group discussion highlighted an association between 'discriminating', 'risk cognisance' and winning and retaining public confidence through the need to be *publicly seen* to follow a 'correct' process (See Box 11.11). This association had not been raised during individual interviews. However, one might argue it was a motivator

in establishing the consultant psychiatrist as the clinical team leader (attempting to restore public confidence). Individually it had appeared with regard to defensive contingency and the immediate reporting of risk incidents. It also was a feature of the DCEO's comment that he sometimes felt that the process of being seen to hold consultative meetings was more important for the DHA than the actual content and outcome.

"I think the public is more interested in process because that enables them to trust the service. For example, in mental health in particular nobody ever believes the outcome is going to be that they are going to kill themselves. "So I am going to trust your process because I believe you did all the right things for my Jimmy, my whatever" right? "OK, so the outcome is like that, well we know between 18 and 25 year-olds there is a 78% increase in the likelihood of suicide and all the rest of it, he was just one of those, it was unfortunate but the actual process that you went through we like to think that you have done absolutely everything for their particular boy".

Deputy Chief Nurse Adviser

"Yeah I agree with that and also for the public, they are concerned about not just their relatives but the next door neighbour or the guy down the street. You know are they going to be able to keep him out of hospital, is he going to keep away from me and my family and not do anything untoward whilst he is in the community, you know, are you going to make sure of that? You know, they are the kind of questions that are always thrown at us."

General Manager

Box 11.11
The importance of process in projecting implementation

Baum (1984) identifies an important concern for policy implementers as being subjected to an investigation of their implementation by an outside agency, for example Government, and public exposure of error or non-implementation. It would appear for some managers that within their discussion, conforming to correct process was sometimes as important a feature of implementation of policy as its outcome, and perhaps in the case of the ACNA process was the more significant issue of implementation. The implication of the association between these three elements was that ensuring conformity to processes was an important means of protection from public/ political criticism.

This observation derived from the group interview may also be seen in the discussion of the 'embedded' relationship between the DHA and the Trust (See Section 11.1d). In this context one may view DHA commissioners as 'delegated' policy 'enactors' with a

watching brief to ensure implementation compliance. However, their willingness to utilise their power to investigate and publicise seemed to be limited by contextual political exigencies combined with the closeness of their relationships with the Trust managers, the latter apparently consciously exploiting this as a means of deflecting comprehensive compliance demands. What enabled the Trust management to respond in this way was the wider policy reluctance to specify implementation processes combined with a context of competing/ ambiguous policy goals.

11.5 Conclusion

It might be argued, in line with Fisher's (1998) view, that a number of managers judged policy significance in relation to the degree implementation needed to be projected to political and public audiences. Thus for example despite the fact that CPA and SMI had been identified by the Government as central to mental health policy from the early 1990s it is only when political/ public concern about mental health care required that services demonstrate that they were effectively managing people with SMI that one sees a greater emphasis on implementation. Equally, the policy implementation of clinical team leadership assumes an importance once there is a realisation of a need to project authority outside of the Trust to stakeholders and potential medical recruits and internally to medical staff in post. This need to 'project' however, did not necessarily mean that managers were in sympathy with policy they judged significant, for example exclusive focus on SMI or Supervision Registers.

Some managers seemed to feel 'affectively' compromised in relation to services and/or clinicians as a consequence of a conflict between a general support for policy, for example retention of public and political confidence derived from an awareness of a need to manage risks, with a heuristic that emphasised utility and equity. A number of managers' discourse demonstrated a 'discomforted' affiliation with central policy relating to the degree to which they perceived it as an implementation problem rather than guide or objective to be achieved. The means they chose of dealing with this was to adapt the policy to the 'realities on the ground' - that is transform the policy through control of the flow and content of information to both external stakeholders, such as the DHA, and lower level implementers, the clinical teams, so as to demonstrate and meet an adequate level of implementation. The significant factor that seems to have

facilitated the establishment of an 'adequate' as opposed to 'full and rigorous' implementation attitude amongst managers was the informal aspects of inter-personal relationships and communication combining with the capacity perspectives of many managers.

A number of managers in the Trust appear to have viewed overall central policy prescription as at times antagonistic to their local management position. It has been argued that previously established ways of doing things combined with the degree to which policy interferes with implementers' spans of autonomy affects the way policy is perceived and implemented (Allison and Zelikow, 1999). Thus the expressed anxieties by some Trust managers about the future influence of primary care and the view of central policy as overly interfering and prescriptive can be explained as arising from concerns that their established spans of control and practice were threatened, which in turn was seen as affecting the overall ability to deliver a coherent and uniform service. Garn (1999) argues that such considerations lead to a general lack of implementation rigor on the part of affected actors. One may for example argue that the Trust management's attitude towards and enforcement of Supervised Discharge is an example of this.

To conclude, as discussed in Chapter 5,[98] managers in the public service often experience conflict between what they are required to do by government and their own public service ethos. Fisher (1998) argues that such managers' implementing priorities in this regard are resource driven in relation to acceptability to differing audiences. However, it would appear from an examination of the issues discussed by these managers that whilst resources were an issue other factors, such as their need to retain certain clinicians' co-operation or demonstrate implementation to Government, were also important factors. This was related to inter- and intra-affective responses to policy and the need to translate implementation into something that was 'admissible' to these audiences as a means of mediating their own anxiety about policy and its implementability (Levi, 1990). The degree to which clinicians shared or differed in their implementation concerns at 'street level' is the subject of examination in the next Chapter.

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[98] See Chapter 5, Section 5.1

CHAPTER TWELVE

CMHT Milieu: 'Living Inside The CMHT'

12.0 Introduction

As indicated in Chapters 2 and 3 the question of whether the CMHT could operate effectively in the delivery of mental health policy was and continues to be a question of investigation (See for example, Villeneau *et al.*, 2001). Peck *et al.*, (1999) reported that in 1997 managers in London saw problems relating to the establishment and management of CMHTs as their top policy priority (See also Peck and Wigg, 2002). For example as we have seen the Trust managers in this study perceived CMHT internal governance as a policy problem.[99]

The milieu as it relates to the internal and external boundaries conceptualised within a team is significant for understanding how street level bureaucrats come to implement policy since this is an important mediator with regard implementation and issues of policy tension within CMHTs (Lipsky, 1980; Wolf *et al.*, 2000).[100]

This and the following Chapter presents data arising from the interviews conducted with members of the two Trust site CMHTs and observation of their meetings. This is supplemented by data generated from two group interviews conducted with a range of professionals allied to medicine (PAMS) to be found working within CMHTs in the case site and another group interview with psychiatric medical staff. This Chapter explores the influences on clinicians' view of the CMHT and its role.

Section 12.1 provides a brief overview of the issues involved in accessing the two CMHTs and the group interviewees for this case study. Section 12.2 examines the data

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[99] See Chapter 10, Sections 10.2e and 10.2f
[100] See also Chapter 5, Section 5.2a

in relation to the degree that clinicians identified with the CMHT and how they located its and their practice role.

In Section 12.3 the internal *modus operandi* of the CMHT is examined in relation to team etiquette and tensions. Section 12.4 extends this further by examining how the CMHTs engaged with their external environment particularly in relation to the management of practice demands. Finally, in Section 12.5 it is argued that the issues identified from the data is underpinned by the concept of CMHT and individuals *span of control.*

12.1 Accessing CMHTs

The case site's community mental health services contained six generic CMHTs. Of these, it was decided to observe and individually interview the members from two teams recommended by the DCEO.[101] For the purpose of group interviews members of four other adult services' teams were contacted via telephone to gauge their interest in participating in a group interview followed by letter. To further encourage attendance of these groups each respondent was paid £50 in recognition that they were giving up their personal time.

It was decided to observe each team over a period of three months, followed by the allocation of a month in which to conduct interviews with the members of the team. It was felt that spending three months with each team would strike a balance between the need for the team to become accustomed to my presence and gathering of sufficient data for analysis.

A meeting was held with the two clinical team leaders of the CMHTs (CMHT A and CMHT B) in September 1996. At the time both agreed to participate, on condition that their respective team members had no objection. No such objections were forthcoming. However, in January 1997 one of the teams (CMHT B) was amalgamated with a smaller CMHT and a new clinical team leader was appointed. This necessitated another meeting with the new team leader, though he too agreed to providing access to the 'new' CMHT.

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[101] See Chapter 7, Section 7.3 for a discussion of some of the research and ethical issues raised by this.

CMHT A was joined in February 1997 and CMHT B in May 1997, the period of observation with the latter ending in the first week of August of that year.

This episode was instructive of the contingent context within which these teams operated at this time. It would appear that in September no one was actively aware that this service re-configuration was to occur. It transpired that the amalgamation had taken place to better serve local GPs, particularly the TPP;[102] again perhaps indicating the responsive necessity of the Trust to the power of such primary care commissioning structures and their increased financial significance within the climate of resource restrictions and reductions in expenditure initiated by the DHA from September 1996 onwards.[103]

12.1(a) Profile of CMHT A and CMHT B

The standard configuration of a CMHT in the Trust included a consultant psychiatrist, a senior registrar, a psychologist, between 4 and 6 Community Mental Health Nurses and social worker. However, there was wide variance between individual teams as Table 12.1 shows. Thus CMHT A consisted of a consultant psychiatrist, a senior registrar, a clinical assistant, three social workers, one occupational therapist and three Community Mental Health Nurses. There was a vacancy on this team for a clinical psychologist.

CMHT B consisted of a consultant psychiatrist, a senior registrar, one full-time and one part-time psychologist, one occupational therapist (with one vacancy) and five Community Mental Health Nurses. The team had one social worker attached to the team, not based with the other CMHT members in the team offices, but based in the offices of the local social services department.

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[102] See Chapter 8, Section 8.4a
[103] See Chapter 8, Section 8.3a

Table 12.1 CMHT Sample

Position	Consultant Psychiatrist (CON1)	Senior Registrar (SR1)	Clinical Assistant (CA)	Community Mental Health Nurse (CMHN1)	Community Mental Health Nurse (CMHN2)	Community Mental Health Nurse (Tape lost)	Occupational Therapist (OT1)	Social Worker (SW1)	Social Worker (SW2)	Social Worker (SW3)
Gender	Male	Female	Male	Male	Female	Male	Female	Male	Male	Female
Years as member of CMHT at time of data collection	6 year	0.8 years	4 years	0.3 years	4 years	5 years	3 years	2 year	2 years	2 year

CMHT A

Position	Consultant Psychiatrist (CON2)	Senior Registrar (SR2)	Community Mental Health Nurse (CMHN3)	Community Mental Health Nurse (CMHN4)	Community Mental Health Nurse (CMHN5)	Community Mental Health Nurse (Tape damaged)	Community Mental Health Nurse (Avoided interview)	Occupational Therapist (OT2)	Psychologist (Psych1)	Psychologist (Psych2) (Agreed to group interview)	Social Worker (Avoided interview)
Gender	Male	Female	Male	Female	Female	Female	Male	Female	Female	Male	Male
Years as member of CMHT at time of data collection	0.5 years	0.2 years	0.5 years	0.5 years	0.5 years	0.5 years	Unknown	0.5 years	0.1 years	0.5 years	unknown

CMHTB

Overall composition of both CMHTs reflected that which was found in other studies conducted at the time.[104] Only the CMHNs in both teams were full time in that they had no responsibilities outside of the team. For example, the two consultant psychiatrists, the psychologists and one of the occupational therapists (from CMHT B) also had work commitments on the in-patient units; the social workers had child protection responsibilities in their respective local authorities. This was a similar position to the wider national picture at this time (Onyett, 1998).

Team members were asked to state how many years they had been in the CMHT. The average number of years for membership of CMHT A was two years and nine months, indicating reasonable membership stability.

It will be noted that most members of CMHT B gave a membership figure of five months. However, this was because the team had been in existence for this amount of time. In fact most members of the team had been located in the previous CMHTs for at least a year or more (though two members of the team – CMHN 3 and CMHN 4 - had been re-deployed to the team from a day hospital that had been closed).

12.1(b) Observation of meetings

The conceptual framework indicated a need to examine activity where there was an observable inter-face between policy, managers and clinicians. Discussions with the two clinical team leaders indicated that this was usually the team business meeting, which was attended by the respective service managers. There was also a need to observe meetings where the team were required to interpret policy. Again following discussions with the team leaders it became apparent that this was the weekly referral meeting. These meetings constituted the two key regular activities in which all members of the CMHT met together for the specific purpose of engaging in whole team activity in relation to policy.

CMHT A held two meetings per week. The first, the 'team meeting', took place on a Wednesday afternoon from 2pm and usually finishing between 5 and 5.30pm. This

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[104] See for example Chapter 2, Section 2.2b.

meeting was dedicated to the discussion and allocation of new referrals for assessment amongst team members; reports to the team on assessments carried out; discussion of problems relating to individual users in CMHT members' caseloads and team responses.

The second meeting, what the team referred to as the 'business meeting', was held on Thursday morning from 9am and usually ending at between 10 and 10.30am. This meeting was specifically designated to discuss issues not pertaining to specific user care but rather dissemination of general information with regard such things as new policies. The service manager (OPM1) also attended this meeting.

CMHT B held one combined 'team' and 'business' meeting per week, on a Monday afternoon from 1.30pm, usually finishing at between 5 and 5.30pm. The 'business' element of the meeting usually took place in the first 30 to 40 minutes and was attended twice by the service manager (OPM2) during my time with the team.[105] Following this the team held what they referred to as the 'referral meeting', which featured the same content as CMHT A's 'team meeting'.

In addition to this meeting on Monday, the clinical team leader initiated a regular CPA review meeting, (referred to as the 'case review meeting'), two weeks after observation had begun. This took place every Tuesday morning at 10 am and was scheduled to last 90 minutes.

The team leader said this meeting was an attempt to improve team compliance with CPA requirements, particularly in relation to maintaining up-to-date care plans. These meetings were also observed; however, attendance by team members was poor (the average attendance was four). For example, in the first meeting the team leader and three CMHNs attended. At the following meeting only three CMHNs attended.

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[105] I learned during my time with the team that the service manager held a meeting with the clinical team leader once every two weeks and agreed to meet with individual members of the team as and when they requested.

This poor attendance was despite the fact that the team leader raised the level of attendance at these meetings on one occasion; explicitly stating their importance, since the latest review of CMHT B's CPA plans had found that whilst most users had a CPA plan only 23.5% were up-to-date. However, his own intermittent attendance combined with a statement that all the users for whom he was a keyworker did not need multi-disciplinary input and therefore did not need to be discussed, seemed to indicate that he too had some ambivalence about the importance he attached to the meeting.

This lack of attendance of a meeting associated with a policy requirement so emphasised by both the Trust and nationally provided an indication of three points of interest. The first was the degree to which the relationship between the clinical team leader and the other members of the team was perhaps both authoritative and tense. Secondly, the poor attendance of this meeting seemed to indicate a lack of commitment to the CPA policy. Finally, it was notable that the only members who regularly attended this meeting were CMHNs. This could be taken as an indicator of the degree to which some CMHNs who attended were socialised into following the instructions of medical staff compared to other professionals (for example psychologists) or their sense of feeling comfortable with the CPA because it had a synergy with the nursing process.

12.1(c) Individual interviews

Individual interviews with the members of each team were conducted in each respective team base, tape-recorded and transcribed. Interviews took place in the month following the end of the observation with each team. It was decided to do this for two reasons. The first was it was felt that to interview team members whilst observing the meetings could 'contaminate' the behaviour of clinicians during these activities. The second reason was that observations of the meetings provided contextual points of reference that could be later explored with individual respondents.

12.1(d) Group interviews

The interviews with other CMHT clinicians (doctors and PAMs) were held after the completion of data collection in both teams and following a preliminary data analysis of the CMHT data in October and November 1997. Though a uniform number for

participation was attempted this proved impossible because of either cancellations or reluctance to participate. Nevertheless, the membership of the group interviews appeared to reflect the range of professions to be found in the CMHTs (See Table 12.1b).

Professionals	Consultant Psychiatrist	Senior Registrar	CMHN	Social Worker	Psychologist	Occupational Therapist
Group						
Medical Group	CON 3; CON 4	SR 3				
Professions Allied to Medicine Group (PAM 1)			CMHN 6; CMHN 7; CMHN 8			OT 3
Professions Allied to Medicine Group (PAM 2)			CMHN 9	SW 4	PSYCH 2	OT 4

Table 12.1b
Distribution of professionals amongst interview groups

12.1(e) The CMHTs' response to my arrival

Both teams were located in their own suite of offices in the community in what were designated by the Trust as 'team bases'. CMHT A operated from a purpose built unit, which it shared with another CMHT. On the other hand CMHT B operated from a small cottage hospital and was the only mental health team operating from this unit.

Initial project information giving meetings were held with each team in the third week of January 1997. At both meetings I was received in a friendly manner since I was known to some of the members in each team. Those present asked questions about the project and what I intended to do. I informed each of my projected start date.

The initial response experienced from each team however once I started regularly attending their 'business' and 'team' meetings was quite different. Whilst both showed some discomfort on my initial arrival (for example occasional glances in my direction during discussion) CMHT A quickly grew accustomed to my presence and indeed appeared to be both comfortable and inclusive in their approach to me as time went

on.[106] The degree to which this 'comfortable' attitude was a feature of my relationship with CMHT A can be gauged by the fact that all members of the team, when approached, agreed to be interviewed.

June 30th 1997 referral meeting

Just before meeting proper got underway I reminded the group that I would be approaching them in the next two weeks to arrange individual interviews. There was an awkward silence for a few seconds broken by CMHN4 who said that would be fine with her. Others nodded in agreement. Then CON2 moved meeting on. I felt very awkward at this moment as though I had intruded.

During the tea break CMHN 5 asks me what I record in my note book during the meeting and why. CMHN 4 says 'task and process' to my reply. It was difficult to decide how to handle this conversation but I decided to answer all questions as a means of building a trust relationship.

Overall reflection on the day

I feel that this group still view me as intrusive and are slightly suspicious of me, such a contrast to the previous team's attitude!

Box 12.1
Field entry notes and reflection on my relationship with CMHT B

My reception and relationship with CMHT B was comparatively tense throughout my time with the team (See Box 12.1). On my first attendance of a team meeting I was asked to leave prior to a team discussion of a number of suicides that had occurred amongst patients managed by the team.[107] Though this was the only occasion when I was asked to leave a team discussion I did not feel wholly comfortable within the team subsequently nor, do I think were they as a group wholly comfortable with my presence, though at an individual level relations were relaxed.

In attempting to account for this difference of response in both teams an important variable appeared to be the length of time that each team had been established and as a consequence the degree to which members felt comfortable with each other in the group setting. As Table 12.1 shows CMHT A had been established for some time with a fairly stable membership. On the other hand CMHT B was newly established and headed by a team leader who was newly appointed to the Trust and about whom there was some feeling of tension. The attitude towards me therefore appeared to be indicative of inter-

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[106] Though as I indicate in Chapter 4, Section 4.5(d) this 'inclusiveness' was problematic in terms of data collection.
[107] See Chapter 7, Box 7.4

personal conflict and tension to be found in the CMHT milieu that was established in each team.

12.2 Affiliation and role

Identity and role have been seen as significant issues in relation to the functioning of the CMHT (Patmore and Weaver, 1995; Brown *et al.* 2000). Lipsky (1980) sees the team as a normative enforcing environment in relation to the street-level bureaucrat's implementation of policy. This, taken with Ostrom's (1999) concept of an *action arena* of implementation analysis, means that the CMHT's construction of social meaning and identity and its interaction with the operational world is a significant issue for implementation analysis.[108] This section examines perspectives of internal agreement and difference/ tensions within teams about affiliation and role and how these related to the external relations of the CMHT.

12.2(a) Affiliation

As indicated in Chapters 2 and 3, the CMHT was a significant vehicle through which community care policy was to be implemented. A number of mental health policies at national and local level, for example the CPA and clinical team leadership, attempted to influence the clinical activity, accountability and affiliations of practitioners within the CMHT so as to achieve a more effective policy implementation. Individual perceptions of membership and role within the CMHT as opposed to other connections, for example professional identities, is therefore important in terms of the influence of these 'thought communities' on how individuals viewed policy and their compliance with it.[109]

An examination of the managerial and professional reporting structure for medical staff indicated that their accountability was structured within the CMHT through the Consultant Psychiatrist as clinical team leader and the senior medical professional to the rest of the medical hierarchy.[110] Alternatively examination of the reporting structure for the other members of the CMHTs indicated three reporting and accountability lines to

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[108] See Chapter 4, Section 4.1a and Chapter 5, Section 5.2c
[109] See Chapter 10, Section 10.2e; Chapter 5, Section 5.2b and 5.2c
[110] See Chapter 9, Fig. 9.2

negotiate - the service manager, the team leader and their professional manager.[111] The degree to which individuals were cognisant of these reporting structures appeared significant for the degree to which they felt an affiliation with the CMHT.

> "It was a case of, em... It was very difficult because potentially, I've got three different managers, really, who all have some kind of say as to how I spend my time. It was very difficult to actually please all of them and know what all of them wanted, and try and synthesise it somehow into one job."
>
> **Occupational Therapist 2**
>
> "My line manager is, X, who's a team manager in Social Work. So I straddle this strange mix that in a sense, I'm freed up to be more challenging than some people in this team, because the people writing my references aren't health people. I don't want to fall out with my consultant because good working relationships are very important to me. But it wouldn't cost me my job, literally, if I did. Or the fantasy that it might damage my future greatly - in fact, it might be an asset ! Might be seen as quite a good thing to have done in social work, not to be too medically dominated. So I'm aware I have a different rôle from most."
>
> **Social Worker 2**

Box 12.2
Uncertainty and advantage – diversified reporting

Some respondents found three lines of accountability 'difficult' in terms of identifying and meeting the agenda of each (See Box 12.2). However, it is also notable that the social workers found this diversification of reporting and accountability an advantage in that they saw it as conferring upon them a 'policy independence' from the Trust and clinical team leader denied to other members of the CMHT (See Box 12.2).

Perhaps because of this lack of diversified reporting and in contrast to other CMHT members, doctors said they did not primarily identify with their CMHT but rather with the wider medical body in the Trust (See Box 12.3). For example, it is notable that neither CMHT consultant indicated that they derived affective support from the team. Observation of both CMHTs seemed to indicate an 'affective' distance of each consultant from the CMHT and interaction as a source of stress for both. One of the consultants at group interview emphasised that he derived his 'affective' support from other consultants because he felt that the other professions in the CMHT were not able to empathise with the particular professional strains to which he was subject.

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[111] See Chapter 9, Section 9.2 and Figure 9.2

"It is difficult. If I was to answer I would say I am a psychiatrist working in (LA2). I identify with my consultant colleagues but I work quite a lot with the GPs."

Consultant Psychiatrist 2

During the break CON1 and SW1 have a major disagreements about the course of action to be taken with this patient. This row takes place in front of many team members. Whilst no shouting takes place the conversation between the two members is robust and there is clearly some ill feeling.

At 3.30 pm meeting starts again. SW1 looks fed up. CMHN2 feeds back on a Pt.X. CON1 comes in late and looks like he has been crying (very fed up looking). CMHN2 says he called around to the patient on Monday and met him in the lift. The patient appeared paranoid, refusing to talk ; CMHN2 left. She went with CON1 yesterday but the patient was not there. SW1 asks CMHN2 if she's contacted his mother. CMHN2 says no and asks what do you think? CON1 says we'll have to arrange another Mental Health Act assessment. The meeting seems very subdued.

Observation notes CMHT A, referral meeting,

Box 12.3
Consultant distance and stress within the CMHT

A number of clinicians in both CMHTs, other than medical, indicated their affiliation as increasingly located within the team. This feeling appeared to be strongest amongst CMHNs (See Box 12.4). Their stronger identification with the team, particularly prominent within CMHT A and in the group interviews, appeared to result from an uncertainty about their line of accountability since, unlike the other professions in the team, they operationally reported to the service managers of each CMHT.[112]

Other members' affiliation with the team seemed to be more contingent and qualified, possibly because they were accountable to a reporting structure outside of the CMHT. PSYCH 1, for example, reported that she had a separate identity and professional relationship with the psychology department and that this made it difficult for her to feel part of the team.

The occupational therapists' (OTs) affiliation seemed to be affected by an anxiety relating to their 'worth' in the CMHT. They appeared to feel isolated within their

[112] The Chief Nurse Adviser had no formal management authority in relation to CMHNs in the Trust since her role was to provide nursing advice to the Trust board. Her role in relation to staff was to provide them with professional advice and to oversee their professional development.

respective CMHTs, stressing that they were managerially accountable to their head of department and engaged in work outside of their CMHT duties (See Box 12.4).

> "I feel allegiance to the team as well but it varies in that I probably get most of my support from the team but I suppose I also feel like there are OT issues that I can't deal with in the team. Perhaps there it is more easy for you to deal with, being one of three CPNs in the team, I don't know. I feel very bad now."
>
> **Occupational therapist 4 , PAM 2**

Box 12.4
'Affiliative isolation'

Some of the social workers said they increasingly identified with the CMHT because of their regularity of contact with other CMHT members and because most of their work was generated through the CMHT. However, all said they were increasingly required by their management to be engaged in child protection work and provide 'emergency cover' external to the CMHT. Two stated that they valued their reporting independence and still wished to retain it as a means of supporting their professional autonomy in relation to the consultant psychiatrist in particular and choose whether or not to accept or reject instructions from the service manager.

A number of clinicians described the affective support within the CMHT and from individual members in terms of a 'connectedness' from which they derived a sense of security in their day-to-day work, based on a combination of ready access to different perspectives and professional validation (See Table 12.2). This was particularly emphasised by some with regard to sharing risk,[113] whilst others said the proximity of close working had facilitated the forging of individually 'affective' relationships.

'Proximity' may also explain why affiliation within CMHT B appeared weaker than that to be found in CMHT A (See Table 12.2). It was noticeable, for example, that only one CMHN from CMHT B indicated cohesive security derived from the CMHT as an aspect of affiliation. Indeed, when this was further examined it was clear this was an aspiration rather than the team's reality. However, despite the fact that CMHT B

[113] See also Box 12.20 below for an example of risk sharing in action.

members, other than the social worker, were located on one site, members rarely saw or interacted with each other outside of formal meetings.

CMHT A

Affective feeling about team membership	Sense of cohesive security	Source of clinical support	Individually supportive
Sample unit			
SR1	1	1	0
CA1	1	0	0
CMHN1	1	1	0
CMHN2	0	1	1
SW1	0	0	0
SW2	1	1	0
SW3	0	0	1
OT1	0	1	1

CMHT B

Affective feeling about team membership	Sense of cohesion	Source of clinical support	Individually supportive
Sample unit			
SR2	0	1	1
CMHN 3	0	1	1
CMHN 4	1	1	1
PSYCH1	0	1	0

Table 12.2
Reported 'affective' support derived from CMHT membership
(1=coded; 0=uncoded)

Lipsky's (1980) construction of the team as a reflexive environment[114] is useful in understanding the process of identity 'seepage' that seemed to be taking place in relation to these CMHTs.[115] Degree of 'seepage' appeared to be connected to the *proximity* of clinical and 'affective' support that some said they derived from their CMHT membership. In the case of the consultants for example, their sense of uniqueness within their CMHTs ensured their sense of identity was one of leadership rather than membership *per se*. Alternatively, for many CMHNs the CMHT was their

[114] See Chapter 5, Section 5.2c
[115] See Chapter 10, Section 10.2f

primary mechanism for clinical and affective support. The rest of the disciplines' affiliation appeared to lie somewhere along this continuum.

Role and activity construction	Pre-emptive assessment	Statutory consciousness	Maintenance of SMI in the community	Be a key worker
Sample unit				
CA1	1	1	1	0
Con1	1	1	1	0
Con2	1	1	1	1
CPN2	1	1	1	1
CPN3	1	0	1	1
CPN4	1	0	1	1
CPN5	1	0	1	0
OT1	1	1	1	1
OT2	0	0	1	1
PSYCH1	1	0	0	0
SR1	0	1	1	0
SR2	1	0	0	1
SW1	1	1	0	1
SW2	1	1	0	1
SW3	1	1	1	1
Medical Group	1	0	1	1
PAM 2	1	1	1	0

Table 12.3
Role conception (1=coded; 0=uncoded)

12.2(b) Role

Many practitioners shared the perspective that theirs and the CMHT's role[116] was to maintain and work with people with SMI (See Table 12.3). A number of clinicians displayed a 'risk consciousness' in defining their role as it related to assessment and their statutory responsibilities (See Box 12.5).

A number of respondents had clear views as to their unique role within the CMHT. Thus the Consultant Psychiatrists emphasised their leadership role. They elucidated this in terms of protecting the teams' clinical boundaries and overseeing the workload of the

[116] I use the term 'role' here as meaning 'the part played by a person in a particular social setting influenced by his expectation of what is appropriate' (Collins, 1999).

members of the team. Both psychologists in the individual and group interviews emphasised their clinical independence as the defining feature of their role. Social workers too articulated the autonomous nature of their work, locating this with reference to their statutory obligations and their separate management structure.

> "With all these new sort of rules and regulations that we are expected to get everybody to follow, everybody is to have a care plan and we have to consider people for Supervision Registers and Supervised Discharge; if somebody, if they are on it and something goes wrong we are potentially in trouble. If they are not on it and something goes wrong we are potentially in trouble too because it is asked why wasn't this person on the supervision register, they had committed a violent act. So I think that is a worry for all of us sort of suicide and homicide and obviously there is, you know, suicides and homicide inquiry and these things are so high profile and you see it on the news and I think there is very much a feeling that it is about having a named person to take the rap when something goes wrong. I think that makes people feel very anxious and defensive and I think that is an enormous change that has occurred in psychiatry over the last few years."
>
> **Senior registrar 1**

Box 12.5
Statutory disaffection and risk consciousness

Some respondents expressed uncertainty and dissatisfaction with their role in the CMHTs. A number of CMHNs said that there was little guidance as to the specifics of their role and complained about what might be termed a 'borderless genericism' in which they took users on to their caseload that other team members did not want (See Box 12.6).

> "Well, I'm a community psychiatric nurse. Responsibilities ! (Laughs) There are many ! I sometimes get a bit lost in. sort of things myself generally. Since I came into the job, it's just felt like my role has changed quite a lot. It's a bit difficult to identify which is the 'nurse' bit, which is the 'social worker' bit, which is the 'benefit officer' bit, 'housing' bit, 'cause the responsibilities incorporate quite a lot of that."
>
> **CMHN 2**
>
> "And there is a sort of almost at a micro level there is this expectation that you will provide that; yet realistically it is a bit of a bottomless pit and I sort of I think well I, you know, I think that the experience I have had over the years I have been a CPN is that there is more and more pressure to meet everybody's needs without very much guidance or input as to how you are going to do that"
>
> **CMHN 6, PAM 1**

Box 12.6
The 'Borderless genericism' of CMHNs

All the OTs tended to define their role in negative terms. Thus they drew attention to the fact that they were not involved in sectioning or medication issues as differentiating

them from other CMHT members. However, the OTs from the two CMHTs felt that this lack of 'regulatory' power meant that their contribution was seen as of less value compared to others.

12.2(c) Concluding comments – 'proximal' and 'contingent' identity

Overall, one may argue that 'affective' isolation, the strength of professional and reporting relationships outside of the CMHT and the degree to which work was generated through the CMHT were important factors in determining individuals' affiliations and role conceptions within the CMHT. Individuals with affiliations external to the CMHT appeared more likely to emphasise their autonomy and have specific conceptions of their role.

Some CMHNs, whose affiliations were focused within the CMHT were more likely to subsume their role within a broader remit, though the degree to which they found this professionally satisfying is open to question (Sainsbury Centre, 1997; Brown *et al.*, 2000). A number of OTs, despite a strong external affiliation, appeared to lack an affirmative role conception because they felt denied the imprimatur of a statutory and regulatory implementing role.

Spillane *et al.* (2002) point out that the actor's perspective of their situation is an important influence in their interpretation and behaviour within implementation. Lipsky (1980) argues that the social reflexivity of team membership serves to promote the individual's self-concept and therefore being considered 'part of the team' and maintaining that membership becomes an important consideration in individual implementing decisions.

The interaction of external identifications with their statutory role, appears to have determined the degree to which some members saw the CMHT as a significant 'thought community' in which members' affiliation and sense of worth and well-being were located. In this sense CMHT identity was proximal and contingent.

12.3 Team tension and team etiquette

Lipsky (1980) identified informal group routines and rules as important policy mediators, particularly within the context of team membership.[117] These might be regarded as the customs that regulate relationships within the team – its etiquette; that serve to govern individual expectations of the team and vice versa; and which may be a source of tension (Stark *et al.*, 2002). They also contribute to determining the reflexive milieu or 'culture' of the group through which individuals learn from one another and develop attitudes towards policy and mediate possible confusions around its implementation (Spillane *et al.*, 2002).

This section therefore examines the routines within the two CMHTs that governed relations between members and with their work. It also considers informants' perspectives on these issues in terms of their ascribed significance, particularly as this related to a supportive or tense milieu.

> "Philosophically, we're all equals in a team; I don't think the reality is such! I think that is the reality, that however egalitarian the consultant may be, there are times when he or she will - or perhaps all the time, but I would say there are times - when he or she will pull the punches and say: 'Right, that is going to happen. It doesn't matter what you do, this is the way it is'."
>
> **Social worker 3**
>
> " It might be 'clinical team leader', I don't think it is. Anyway, that he was given that role, he was assigned that role. There was nothing democratic about it. The consultants in the team are in that role. So there's sort of power issues that go along as well."
>
> **Occupational therapist 1**
>
> "It throws up the very first idea of the team it has any input into team policy, which they apparently do, but they don't feel that they do, I think, em, and well how much sort of authority and power they would have within each discipline I think, I think it is issues around that, I think people would be quite worried that they wouldn't be able to again have their own opinion heard and respected I guess."
>
> **Senior Registrar 2**

Box 12.7
Undermining 'mutuality'

12.3(a) Clinical team leadership and 'mutuality'

The Trust policy on clinical team leadership raised significant comment amongst most respondents in individual and group interview and was occasionally observed as a point

[117] See Chapter 5, Section 5.2e

of tension in CMHT meetings. A number of respondents from both CMHTs spoke of an ettiquette that subscribed to a concept of 'mutuality' (Charles *et al.*, 1997; Rogers and Pilgrim, 2003), that is a shared negotiation of responsibility between members as to the nature of issues that needed to be addressed by the CMHT (See Box 12.7).

Resentment was voiced that the CMHT leadership role had been confined to consultants. This resentment seemed to arise from a perception that it was 'undemocratic' in terms of its introduction and its exclusivity to consultants, thus undermining the 'mutuality' culture of the CMHT. It was felt that it would impose the medical model on CMHTs, making practitioners professionally subordinate to the medical view.

A number of doctors in both CMHTs and in the group interview spoke about the tensions that clinical team leadership could raise in terms of the autonomy of other clinicians. Some saw this as a problem of non-medical disciplines failing to accommodate themselves to a medical model of authority.

Within CMHTB this was a particular issue because CON2 insisted that a doctor be present at all referral assessments, which, according to PSCYCH1, was seen as a direct interference with clinical autonomy. Indeed, a number of members of this time saw CON2's affiliation as more with management than with the CMHT (See Box 12.8).

> "So, I think that they probably (indecipherable) and the team's view was that CON2 is more dedicated to management than he was to the team."
>
> **Senior Registrar 2**

Box 12.8
Consultants as agents of management

Perhaps paradoxically CON2 complained that his authority as clinical team leader over the other members of the CMHT was insufficiently delineated by Trust management, which, he believed, was an attempt to mollify other professionals' hostility to the

policy.[118] He said the consequence was that his authority within the team was often questioned. His view received confirmation from CMHN4 who said that the policy document made it quite clear that the clinical team leader was not the manager of the team and she did not see him as such.

In CMHT B this negative view of changes to the accustomed governance of teams was initially expressed in an overt challenge to the new arrangements that resulted in the 'challengers' - a psychologist and occupational therapist- eventually leaving the Trust. Following these events this challenge according to some seemed to become more passive. SR2 and CMHN5 described how there was an expectation that members of the team would subscribe to a negative view of the consultant as a pre-requisite of team membership acceptance.

> "Because I think that people are sometimes anxious about supporting people because of the attitude of other people in the team. To be honest, it comes back to CON1 again, really. I think that people - There's a potential for people to feel punished in the team. Or slightly pushed down or stamped on or disagreed with - Although sometimes disagreement, I think in a way, is quite a positive sign that the team can actually stand disagreement. And I think that that's a strength and I think that SW2 is very good at that in the team."
>
> **Occupational therapist 1**

Box 12.9
Social worker as conduit for challenge

Within CMHT A, however, such scapegoating appeared to be avoided because of the 'presence' of social workers, whose autonomy was seen by some to temper the exercise of such authority on the part of the clinical team leader in a way that was absent in CMHT B (See Box 12.9). Certainly, it was notable that any overt challenge to a decision by the team leader of CMHT A was voiced by a social worker. However, even in this CMHT a number of clinicians, including social workers, said that they would temper any open questioning of the team consultant for fear of potential career consequences.

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[118] This perspective appears to receive some confirmation from managers discussing this issue (See Chapter 10, Section 10.2g)

Thus there was a tension within team etiquette in which the non-medical members' construction of *mutuality,* which they associated with their own clinical autonomy, was viewed as in conflict with the policy construction of *authority,*[119] which was seen as threatening their autonomy. The newer construction was accepted but *passively* resented.

12.3(b) Attendance of meetings

Many, both in individual interviews and group interview, saw attendance of meetings as an important signifier of CMHT membership (See Box 12.10). Within CMHT B attendance projected an inter-related message to members - an overt demonstration of one's commitment to the concept of 'team' and being supportive of colleagues. Individuals who regularly did not attend meetings were therefore viewed as on the periphery of 'the team' and not supportive of clinical colleagues. On the other hand one of those who did not regularly attend seemed to view these meetings as unproductive in terms of work. In her view the only members of the CMHT were herself and the Consultant; therefore as long as she met with him, it appeared, she felt she was participating in 'the team'.

"It's particularly sabotaged by not attending, particularly the monthly business meeting, which I think is very important. Some of the people who I said I don't think are team players, like 'X' and CMHN 5, I don't think they'd come. They choose not to come, on occasion and I would never choose not to go. That just is like... just would not go if you had a choice. I mean, I'd not see a client, or choose not to see a client, unless it was urgent, rather than not go to the meeting."

CMHN 4

"I came yesterday and I stood there, and looked at this desk and thought: 'Where the hell do I start ?' You know ? 'Where do I start ? I've got all this to do. Who shall I start on first?' And it's very, very difficult. I thought I'd better go into the meeting. Get away from it!

CMHN 2

Box 12.10
The etiquette of attendance – an indicator of milieu

Within CMHT A the issue of attendance of meetings did not arise. This seemed to be because it was rare for a member not to be at a meeting. The contrast with CMHT B is

[119] See Chapter 10, Section 10.2e

instructive as to the degree members viewed their respective teams as a supportive milieu (See Box 12.10).

Lack of regular attendance of meetings in CMHT B did not seem to incur any overt costs to the particular individuals (other than some occasional comments during the tea break by one or two CMHNs), possibly because the non-attendees themselves did not seem particularly concerned about being viewed as 'team players'.[120] In this sense therefore, Lispky's (1980) view (and that of Ostrom, 1999) of the normative power of teams in relation to implementation exercised through a desire on the part of the individual to retain team support may need revising. The data seems to indicate that this may only function when a team is recognised as such by its own members. It may also need revising within the specific context of CMHTs and the reluctance of clinicians to interfere with the clinical autonomy of a colleague, thereby a degree of 'opting out' of activities, such as attending meetings that in other types of team might incur censure and punishment.

"One always gets the feeling that everybody is overloaded with work and not able to do things properly. I mean that is the perennial complaint, you know, they can't take any one else on - they're overloaded I think. I think everybody is fairly pressured but it partly comes down to personality, you know, obviously some individuals feel more overloaded than others."

Senior Registrar 1

"You know I am sort of like working real hard and how come you are managing to sit down there? Because you have your own personal pressures with the case load depending on what is happening and either you might be within a team you still have to manage that but maybe not necessarily say too much about it because you know other people are undergoing the same thing really."

CMHN 6, PAM 1

"Also because I want to raise the profile of what OTs do. Also because I want people to be aware of the different pressures on my time. The fact that, yes I have only got twenty keywork people, but that's because I do all these other things too. I think it's important for me because I feel that there is a kind of expectation that - there's almost a sense of competition, how much work are we all doing."

Occupational therapist 2

"Well, I don't know if that is a real, I don't know if that is a sort of unspoken, I don't know if everyone else on the team is doing all the things, so I am a bit afraid to say I don't"

Social worker 1

Box 12.11
'Advertising' workload

[120] I was unable to explore this issue further in the individual interviews since the other two non-attenders avoided my requests for an interview.

12.3(c) Comparative demonstration of workload

Comparative demonstration of workload, through occasionally telling colleagues how busy one was, seemed an important convention within each CMHT. It appeared to serve a protective function by overtly advertising one's worth to colleagues by size, complexity and amount of time one was engaged with one's caseload (See Box 12.11). This seemed to provide a means of deflecting potential new demands on one's clinical time by the rest of the CMHT.

Comparative workloads were also a source of tension within the teams with some saying they felt they carried more of a work burden than others (See Box 12.11). From CMHT A, OT1 spoke about how management targets and monitoring made her conscious of her caseload numbers in relation to other members of the team. This was also supported by OT2 who said that she felt everyone in her team was counting how many people each was key working. A further tension arising from this etiquette for some, was an intra-personal anxiety of team exposure for fear one's overall competency and worth to the team would be called into question (See Box 12.11).

12.3(d) Workload distribution and the 'ceiling of resistance'

Clinicians were asked to describe the size and nature of their caseload. Consultants appeared to have large caseloads compared to other team members, for example CON2 had a caseload of 90, though many of these he saw in the outpatients' clinic. The average caseload size was 25 (CMHT A - 25, with the highest being 35 and the lowest 18; CMHT B - 26 with the highest 35 and the lowest 20). It is interesting to note that the Trust target at this time was 35. A number of respondents said meeting this target was one of the most important concerns in their work.

A number of clinicians in both CMHTs reported that their caseload mainly consisted of people with schizophrenia of whom about one third they characterised as long-term patients.[121] They mentioned patients with three other types of problem - depression, personality disorder and people with anxiety problems. Some CMHNs and social

[121] This was in contrast with the average case load profile of 66% SMI identified in Chapter9, Section 9.1.

workers also said they carried a number of people whose problems appeared to be related to their social and living conditions rather than a mental illness *per se*.

What is interesting about these users is that they did not fit easily into the policy definition of mental illness priority – SMI. Yet a few clinicians said they retained these users on their caseload as a means of managing their potentially disruptive behaviour and thereby avoiding trouble. These were what might be called '*contingency users*' held on the caseload.

Allocation of new users to an individual's caseload took place in the referral meeting. Each CMHT seemed to allocate users to clinicians through a form of 'consensual volunteerism'. This routine seemed to involve a combination of 'turn taking' and individual volunteering. Whilst some said they volunteered on the basis of the clinical balance within their caseload and whether they felt they had the appropriate clinical skills to meet the new user's needs, a number of clinicians said their primary motivator for volunteering to take on a user was a combined concern to demonstrate to colleagues and management that one was complying with policy through meeting Trust case load targets (See Box 12.12).

"I suppose I choose people to try and get a balance of caseload. The reason that I do that is because I'm always anxious that I've got enough people in my caseload. What the pressures are going to be for caseload. Whether people are going to look at my list for caseload. Whether I've got enough people with long-term mental health problems, and basically Big Brother syndrome."

Occupational therapist 1

"I mean recently we have had a sort of target, a target number of cases that we are meant to be reaching introduced to us in the social work side, which sort of feels like a performance indicator and setting a target implies that is going to be increased and if you are not hitting your target you are not a good worker and that you are in competition with everybody else."

Social worker 1

Box 12.12
Motivator for volunteering – need to meet targets

At times during referral meetings there would occur what one respondent later described to me as a 'ceiling of resistance' (See Box 12.13). This was a point at which each member of the team would attempt to resist being allocated further users to their

caseload. This could be done passively through not volunteering to take on the user (two clinicians in CMHT A described this as 'head down', not drawing attention to oneself and waiting to see who would break the silence first) or overtly by arguing that one already had a heavy caseload.

The primary trigger for initiating this 'ceiling of resistance' was connected to patients who had a forensic history and/or a personality disorder. A number of clinicians explained their reluctance to take on such cases in terms of the degree to which they could distract from the management of the rest of their caseload or because of their potential for embroiling the clinician in controversy (See Box 12.13).

CON1 then mentions 'User X', a transfer from central LA1 CMHT. OT1 feeds back that he has failed to attend 2 initial assessment appointments. OT1 says his depot is overdue. OT1 says she thinks he needs allocating, but that she doesn't want to be involved as she doesn't have a handle on him. SR1 asks what he needs? OT1 says many of his needs are around money and custody of his children. 'Trust Ward' staff nurse mentions that he is very threatening towards women. She also mentions that he has an interest in child pornography and has been suspected of rape. OT1 says that the day hospital has a positive image of him.

SW1 says that this did not come out in the transfer notes. SW1 and SW3 are concerned about the issue of child pornography. SW1 says he has phoned the team about money. SW3 says many of his crises are precipitated around money. CON1 says he needs a medical assessment. SW1 asks whether he's on the supervision register. No one knows. There follows a discussion about how the team will assess him. SW1 says he needs a joint formal assessment. CON1 asks if he is being discharged from the day hospital. 'Trust Ward' staff nurse says he had a forensic assessment, usual story-not dangerous enough.

CON1 says we need to grasp the nettle of key worker allocation. SW2 says surely we need to assess before we do this. CON1 says that he has been drifting around for too long. Silence followed by laughter-CMHN 1, let's call numbers out of a hat. OT1 says, I don't want to key work this person. CON1 turns to CMHN1 and says, CMHN1 you look wavering a bit. CMHN1 replies, yes-if I take him I would need support. SW2 says, I think he needs a joint key worker. CON1 asks CMHN 1 to do a joint assessment with CA1 and, he should not be discharged from cottage day hospital.

Observation notes - CMHT A referral meeting

Box 12.13
An example of the 'ceiling of resistance' and risk sharing

The two CMHTs' allocation routine of these difficult users differed. In CMHT A it appeared that on occasion the team leader would either directly ask a team member to take on such a user or threaten team members with a comparative analysis of their case loads within the team forum. However, in CMHT B CON2 indicated that he felt it was

his role to take responsibility for users with a combined forensic history and personality disorder.

The data therefore seems to demonstrate an *etiquette of risk avoidance* arising from a concern about the personal risks posed by persons perceived to have personality disorder (Lipsky, 1980; Beck, 2000). The significant variable that seems to have operated in relation to the 'ceiling of resistance' was an affective one, either in terms of feeling threatened if one did not take on such a user when specifically asked; or in the case of CON2, believing it was unfair for 'junior' clinicians to manage such users. Perhaps in the latter case there was also a sense of needing to have direct control over a potential threat rather than delegate such control to what he saw as a 'junior' clinician, particularly bearing in mind the general relations within this CMHT and the user suicides the CMHT had experienced prior to my arrival.[122]

12.3(e) Concluding comments – mutualism in a context of perceived risk

This data seems to indicate the importance of 'mutuality' in the etiquette of the CMHT and that it was linked to a conception of professionalism, autonomy and discretion. This did not however, mean that non-medical CMHT members rejected the concept of leadership, rather that they disagreed with a Trust policy that confined the governance of the CMHT to the sole remit of the consultant psychiatrist, fearing for the practice route it might take them down and resenting what they saw as imposition rather than consensus. This was set within a context in which there was a need to feel supported and a concern about risk to oneself at a time of change (Wynne, 2003).

Marris (1975 *cited in* Spillane *et al.*, 2002) points out that policy sense making is based upon cumulative schema and ways of doing things. Therefore the more fundamental and different a policy innovation the more likely will actors find it difficult to accommodate. How much more difficult therefore when such a change may be perceived as having the potential to expose the individual clinician to immediate censure within a context of practice risk and uncertainty. In this sense criticism of the traditional democratic

[122] See Chapter 7, Section 7.6(a), Box 7.4

etiquette of CMHTs might misunderstand some of the reluctance to accept change to CMHT customs and structures amongst CMHT members (Onyett, 2003).

12.4 'Boundary tensions' and the CMHT

Lipsky (1980) sees the boundary activity of the street level bureaucrat as central to policy mediation, where the street level bureaucrat engages both individually and collectively to interpret and at times change policy.[123] This section explores this activity as manifested and described by members of the CMHTS.

12.4(a) The CMHT as a repository for risk anxiety

Some resentment was voiced about Trust specialist services, external agencies and GPs because they were perceived to exercise control over the practice environment of clinicians through transferring clinical pressure onto the CMHT. This view seemed to be confirmed in meetings, where it was observed that this transfer was achieved through a process of *clinical deflection* by changes to referral thresholds to specialist services and use of 'urgent referral' by GPs.[124]

> "I think the most frustrating thing is that people transfer their anxieties and responsibilities on to the team, and me in particular. So it's quite - Someone from, I don't know, a day centre, or housing will phone up and say: 'We think this person's violent or is going to do something. You must do something'. Now clearly, in one instance, that may be reasonable, but if you're personally aware that this person has done that twenty times in a year, it's quite exhausting. ... I think what's happening at the moment is with our population is being 'defined by default' as it were: 'If you don't have an eating disorder, you must belong to the CMHT.'"
>
> **Consultant psychiatrist 1**
>
> *CMHN2 mentions an issue of the changes to the mother and baby unit and gate keeping of specialist services. She says it seems that the team is being asked to do a lot. SW3 says we need to clarify our boundaries. OPM1 nods.*
>
> **Observation notes - CMHT A team meeting**

Box 12.14
CMHT indefinite boundaries and risk repository

A number of respondents felt they could not refuse such deflections because the CMHT remit was insufficiently defined by policy guidance and the consequent risk

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[123] See Chapter 5, Section 5.2a
[124] See Chapter 8, Section 8.3

contingencies that might accrue. Thus some felt the CMHT was managing cases by default as the *risk anxiety repository* for other services (See Box 12.21).

Defending boundaries	Appropriate and inappropriate use of resources	Deferential deflection	Maintaining good relationships	Need to define CMHT practice boundary
Sub-unit of analysis				
CA1	1	1	0	0
Con1	1	1	1	1
Con2	1	1	0	1
CPN2	1	1	0	0
CPN3	1	1	1	0
CPN5	0	0	1	0
OT1	0	1	0	0
OT2	0	1	0	0
SR1	1	1	1	0
SR2	0	1	1	0
SW1	1	1	0	0
SW2	0	1	0	1
Medical group	1	1	1	1
PAM1	1	1	1	1
PAM2	1	0	1	0
CMHTA BM	1	1	1	1
CMHTA RM	1	1	1	1
CMHTB TM	1	1	1	1

Table 12.4
The strategy of CMHT management of demand (1=coded; 0= uncoded)

In this sense the CMHTs appeared to be engaged in responding to the attempts of other services to re-configure their own boundaries of practice as a means of protecting both their resource and 'political' position. In effect this could be seen as a transfer of resource loss or 'cost shifting', and responsibility for its consequences onto the CMHT. Literature on the issue of 'cost shifting' tended to see it as occurring between agencies, for example social services and Trusts (Chisholm and Stewart, 1998). However, what

this data seems to suggest is that cost shifting also took place within the same service between different clinical specialities.

12.4(b) Defending the CMHT boundary – remit definition

A number of clinicians advocated a clearer policy on the CMHT practice remit. This appeared to be motivated by a belief that this would provide a greater legitimacy for the CMHT to resist pressure from referring agencies and services to care for non-SMI users than was currently the case.[125]

However, one clinician in the group interviews voiced a reluctance to reduce the breadth of care provided by CMHTs. CON4 felt that the CMHT should manage a broad range of users within the available resource rather than narrow the CMHT remit and only provide care for SMI users.

12.4(c) Defending the CMHT boundary – managing demand through 'deflection'

The two CMHTs appeared to employ a range of strategies to manage demand (See Table 12.4). Both seemed to utilise assessment to deflect demands whilst being conscious to maintain good relationships with referrers, particularly GP fundholders. They did this with reference to the concept of the CMHT as a 'limited resource' in which the boundary was defined by both 'concrete' criteria – for example, whether or not the referred patient lived within the CMHT catchment area – and a more abstract notion of 'appropriate'[126] relating to providing care for SMI users only.

CON1 said that Trust management pressure on the team to maintain good relations with GP fundholders, meant that GPs' referral of non-SMI patients was distracting the CMHT from focusing on SMI care. OT2 encapsulated the dilemma this posed when she said that the limited resources of CMHT B had placed pressure upon the team to refuse GP non-SMI referrals but that the financial significance of GP fundholders and meeting

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[125] The desire to have the remit more formally specified may also have been to allay professional discomfort with refusing care to non-SMI users.

[126] I say 'abstract' here because though clinicians tended to identify SMI with people with on-going psychotic illness, they had not clearly defined what SMI really meant for them.

their needs as emphasised by Trust management, acted as a countervailing pressure to this.[127]

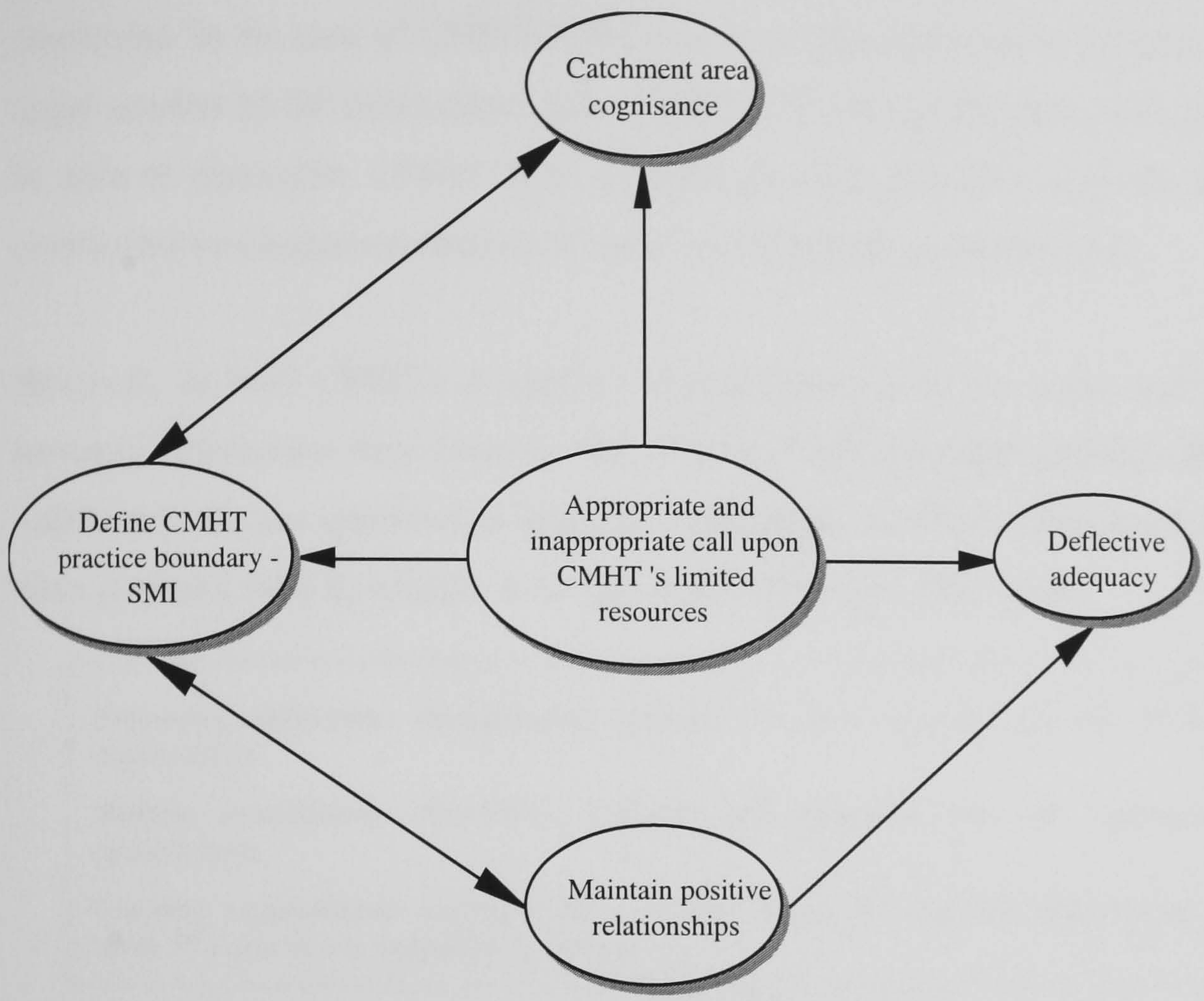

Figure 12.1
Deflective adequacy

The two CMHTs appeared to respond to this pressure by what one might describe as a strategy of *deflective adequacy*, in which the need to comply with the wishes of an important stakeholder was met through a deflection of those wishes elsewhere by initially appearing to engage clinically with the user. For example, CON1 said that CMHT A, in order to ensure actions were defensible with regard an untoward incident, tried to be seen to provide an initial assessment in response to GP referrals which they considered 'illegitimate' in terms of focus of the CMHT, that is non-SMI. A number of respondents spoke about referring non-SMI referrals to other services after an initial assessment, thus responding to the GP's referral without adding to theirs and the CMHT's work burden (See fig. 12.1).

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[127] See Chapter 11, Section 11.2c for an example of the level of anxiety this issue caused the team as described by OPM2.

However, it appears that this strategy was not entirely successful. When the caseload profile was explored with individual clinicians a number described only a third of their caseload in SMI terms (i.e. long-term management of people with schizophrenia and psychosis). In the case of CMHT B this may have been because it served a significantly larger number of GP fundholders than CMHT A. These fundholders were more likely to be able to pressurise CMHT B to provide care for non-SMI referrals through their contractual mechanism compared to their non-fundholder counter-parts.

However, in both CMHTs it appears that another factor for some was the level of personal satisfaction they derived from working with non-SMI patients. Thus personal satisfaction factors appeared to impact on the degree to which clinicians in the CMHTs were prepared fully to comply with the 'ideal' of a strict SMI focus.

Protecting difference: distinguishing between the work unit and the rest of the organisation;

Making connections: developing contacts and engaging with the contextual environment;

Creating commitment: attracting the members' focus onto the unit and creating a sense of a unit that is supportively unique.

Box 12.15
Boundary adaptation
(Adapted from Gulliver *et al.*, 2002)

12.5 Conclusion – Adaptational boundaries and the span of control as source of tension

Gulliver *et al.*, (2002) drawing upon work by Yan and Louis (1999) identify three types of boundary adaptation to change (See Box 12.23). It is possible to see examples of all three levels in the two CMHTs.

Lipsky (1980) argues that street level bureaucrats engage in activity, which in effect changes the intention of policy. However, a number of recent authors have found that street level bureaucrats often work to implement the policy intention (Brehm and Gates, 1997; Firestone *et al.*, 1999). There was both an awareness of difference from other services and a concern to protect that difference through prioritising work with SMI on the part of both CMHTs. Thus in this policy area, the two CMHTs were engaged in

creating and operationalising their own interpretation of policy as a means of compensating for what was seen as insufficiently prescribed and enforced central guidelines. However, it is also clear that some felt vulnerable in engaging in this protecting activity since there was an expressed desire for a clearer remit to focus on SMI from management and government, which was felt would confer a legitimacy that was lacking.

Engagement with the contextual environment was also problematic. Firstly, because awareness of connections with other groups within the organisation, for example fellow doctors, served to obstruct for a number of respondents a sense of whole hearted commitment to the CMHT. Secondly, because for many respondents there was a mistrust of the immediate environment, focused on the intentions of managers, which initiated a sense of uncertainty and anxiety; and the wider environment in terms of the intentions of policy in relation to practice.

Finally, it appears that for some the notion of the team as an environment as the most important environment of support was qualified. There was a discernable difference in this regard between CMHT A and CMHT B, with the former perhaps providing milieu of that was more personally supportive than the latter. However, the policy tensions highlighted within the etiquette of both CMHTs acted as a countervailing force in relation to an absolute sense of unique support.

Onyett (2003) states that level of inter-dependence is important in defining 'a team' with regard CMHTs, though he does not state clearly what he means by 'dependence'. However, it is clear that 'dependency' does have an affective as well as a cognitive and behavioural aspect, involving 'trust', 'commitment', and 'affection'.

It appears that a number of clinicians, with perhaps the exception of CMHNs, were unable to engage fully in this more affective aspect of membership. They identified loyalties outside of the CMHT and, in some cases, for example the consultant psychiatrists, appeared principally to identify with others outside of the CMHT. Indeed, disgruntlement with policy on clinical team leadership could be seen as a principal

barrier to winning the affective as opposed to the cognitive sense of membership of the CMHT for a number of clinicians in this case. Thus one might see the two CMHTs, and particularly CMHT B, more as 'a group' than as 'a team'. In this sense therefore, one might see policy in the Trust at this time as failing in terms of encouraging the CMHT as the principal milieu and point of reference for practice.

The highlighted issues and tensions it could be argued relate to the nature of the 'span of control' exercised by individuals within the CMHT and by the CMHT within a wider environment. Thus CMHT members were engaged with one another in both demonstrating and protecting their span of control, sometimes from one another and sometimes from management. Equally, the CMHT itself was engaged in a struggle with other services in protecting its practice span of control from encroachment by other services. The degree this influenced clinicians' approach to policy forms the subject of the next Chapter.

CHAPTER THIRTEEN

CMHTs And Policy:

Implementation: The Interface Between 'Economic Man' And 'Risk To Self'

13.0 Introduction

This Chapter examines data relating to what appeared to influence CMHT clinicians' perspectives on policy and implementation. In Section 13.1 data relating to clinicians' cognisance, views and reaction to central and local policy is described and discussed. Section 13.2 examines the CMHT relationship with service managers and the communication of policy. Section 13.3 then explores how clinicians described their approach to policy implementation, with a particular focus on their compliance and non-compliance with policy. This is followed in Section 13.4 by examining the affective responses discussed by respondents in relation to the policy environment in which they operated. In Section 13.5 the cognitive schemata that clinicians appeared to employ in relation to policy is considered. Section 13.6 concludes the Chapter.

13.1 Cognisance of policy

In terms of numbers of policies discussed by each individual, the two CMHT consultants were the most policy conscious (See Table 13.1). However, two local rather than national policy areas were raised most often - that of clinical team leadership and meeting local commissioners' needs. Whilst mention of the latter appeared evenly spread between the two teams, the former was mentioned by all interviewees from CMHT B and is indicative of the degree to which this policy was a source of concern in this team.[128] This section therefore examines the views and beliefs of respondents on these policy issues.

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[128] See also Chapter 12, Section 12.3a

CMHT A

Policies	SMI	Supervised discharge and supervision register	CPA	Joint working	Resource reductions	Long term case register	Consultant as team leader	Meeting purchasers' needs
Sample unit								
CON1	1	1	1	1	0	1	1	1
SR1	1	1	1	0	1	0	0	1
CA	1	0	1	0	1	1	0	1
CMHN1	0	0	0	0	1	1	0	1
CMHN2	1	1	1	0	0	0	0	1
SW1	0	0	1	0	1	0	0	0
SW2	0	0	1	0	1	0	0	0
OT1	0	0	1	1	1	0	1	0

Table 13.1 Policy cognisance amongst CMHTs (1=coded; 0=uncoded)

CMHT B

Policies	SMI	Supervised discharge and supervision reister	CPA	Joint working	Resource reductions	Long term case register	Consultant as team leader	Meeting purchasers' needs
Sample unit								
CON2	1	0	1	0	1	0	1	1
SR2	0	0	0	0	1	0	1	0
CMHN 3	0	0	0	0	0	0	1	1
CMHN 4	0	0	1	0	0	0	1	1
CMHN 5	1	0	0	0	1	0	1	0
Psych1	0	0	0	0	0	0	1	1
OT2	0	0	0	0	1	0	1	1

Table 13.1 Policy cognisance amongst CMHTs (1=coded; 0=uncoded)

"it's about whether people really understand what you do and the fact that I often see people for an hour, for example - And so, when people like [Name of clinical director of adult services] moot that people should be seeing six people a day, I just think: 'Fuck off, you've got no idea about what any of us do, really'.

Occupational therapist 1

OT1 asks the clinical auditor what will happen after she has completed her report. The auditor replies that a working party led by the deputy chief executive will examine the results. Con1 points out that he does not have practical experience of implementing care plan standards. He says this epitomises the problem. Sw3 asks if clinicians are going to be involved. Con1 replies yes, "but the deputy chief executive will drive it".

Observation of CMHT A, business meeting in which CPA auditor is reporting to team on the results of her audit of the team care plans

Box 13.1
Formulator 'distance'

13.1(a) Judging policy legitimacy – distance and impact

Local policy was generally judged as lacking legitimacy because originators were viewed as distant from the reality of practice and often lacking a clinical background (See Box 13.1). The view of a number of respondents was that policy legitimacy could be conferred if it took account of clinical advice but this was felt rarely if ever to be done.

It should be noted that the formulator having a professional background for a number of respondents did not confer legitimacy nor reduce criticism *per se*. Thus one senior manager who received regular criticism from a number of clinicians was the Clinical Director of Adult Services (See Box 13.1). This possibly arose from a resentment of medical influence in the Trust for which he was the overt symbol.[129]

Policy legitimacy was also judged by some practitioners in terms of their perception of its impact on them personally. This was linked to the extra work burden and in particular whether it made life more difficult in day-to-day practice. Thus a positive attitude was displayed towards the policy emphasis on SMI because it was seen as providing protection from 'illegitimate' work burdens whereas negativity was displayed towards Trust policy on the closure of a day hospital in part because of the burden this would place on clinicians (See Sections 13.1c and 13.1d).

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[129] See for example, Chapter 12, Section 12.3a

Both Lipsky (1980) and Spillane and Zeulli (1999) identify 'enactment space',[130] that is the arena where policy comes into contact with implementer, as important in shaping implementation because it is in this environment that individuals learn from and shape one another's responses to policy. The group interactions that take place in this 'space' also make visible and validate attitudes to policy and its implementation that might remain hidden at an individual level. One can see this in operation for example in the comments made by the clinical assistant from CMHT A on his valuing of team discussions (See for example Box 13.12 below).

The social milieu of the CMHT provided the 'enactment space' in which 'distance' and 'impact' legitimacy were explored (See Box 13.1).[131] Individual CMHT members could assess policy as it impacted upon them with reference to colleagues, and thereby could shape their approach to its implementation. Thus for example complaints to one another about the personal impact of information giving provided a validation that Trust policy in this area was burdensome, establishing a team milieu which legitimised information recording as an activity that could be deferred (See Section 13.3b below).

13.1(b) Clinical team leadership

Some of the views and tensions resulting from this policy have already been discussed.[132] Though raised in both CMHTs, CMHT B members raised it more as an issue, though those PAMs who raised it in both teams discussed it with the same degree of intensity.

The policy was seen as further reinforcement of the power of medical staff within the Trust, and as suspicious in relation to the motivation of Trust management in implementing it. This was a view also echoed by some in the PAM group interviews (See Box 13.2).

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[130] A term coined by Spillane and Zeulli (1999), Lipsky (1980) indicates this space in his discussion of the significance of teams in interpreting policy.
[131] See Chapter 12, Sections 12.3(a) and 12.3(b)
[132] See Chapter 12, Section 12.3(a).

"I think they've got too much power ! (laughs) Particularly the consultant role alongside the clinical team leader role. I think that's far too much power in one person's hands."

Occupational therapist 2

"The consultant at the end of the day in exchange they have given them more managerial power almost as a means of protecting themselves. This may be a little bit paranoid. I mean I don't agree with the system let me make that clear as well, you know."

Psychologist 2, PAM 2

"I think there has been issues on the team, certainly, about is the consultant more on the side of management or is he on our side, he kind of protects us really and I think it is really ambiguous and changes depending on what the issues are at the time."

Occupational therapist 3, PAM 1

Box 13.2
Clinical team leadership and consultant power

The clinical team leaders were identified by some as the 'agents' of Trust managers, delegated to enforce targets and standards amongst the other clinicians (See Box 13.2). Because of this some said that CMHT members were sometimes hesitant to discuss criticism of management and policy in front of the Consultant. Indeed, some saw the policy on clinical team leadership as a means of Trust management avoiding responsibility for policy consequences by devolving responsibility for implementation to the consultant as team leader, perhaps indicating a general lack of faith in the intentions of Trust management (See Box 13.2).

Overall, there appeared to be a suspicion amongst a number of non-medical respondents that the policy relationship between senior medical staff and Trust management was 'Faustian' in nature. The Trust policy on clinical team leadership had a greater symbolic meaning for many staff than it might have first appeared, primarily in terms of the primacy of medical influence over management compared to other clinical roles and the perfidious character of general management

13.1(c) CPA, Supervision Registers, Supervised Discharge and SMI

It was noticeable that concerns about policy that had a national profile, such as the Supervision Register, were mostly raised and discussed by members of CMHT A.[133] Similar to the views expressed by managers[134] a number of clinicians felt both national and local policy was focused on winning public confidence through the prevention of embarrassing incidents and could be unhelpful to practice.[135] Unlike a number of the managers however, some clinicians did not feel reducing public concern was a legitimate policy goal as they saw the policy as focused on scape-goating clinicians; in an attempt to placate the media rather than improving the overall policy of community care (See Box 13.3).

> "I think the focus really nationally is on stopping these rare and very well publicised disasters, that is the political agenda I think is to, you know, set up all these mechanisms supposedly to stop these people falling through the net, that is the idea behind it as the national agenda. And I guess to a local extent that is the local agenda too."
>
> **Senior registrar 1**
>
> "The big issues is things to do with supervised discharge. To me that feels quite pressurising. It sometimes feels as if the Trust or the government are just trying to satisfy the media and the general public. When you get these bold statements about something that has happened. The Zito case or those kind of high-profile cases and it feels very pressurising that something has got to be done. Sometimes I feel that even though a lot of these cases are investigated retrospectively, after the incident has happened. Personally, I feel that the workers are then scapegoated unnecessarily. I'm not saying that maybe there are not bad practices, yes? But I think sometimes we're scapegoated unnecessarily."
>
> **CMHN 2**
>
> "You know you can see if there was an inquiry and you hadn't seen someone on the supervision register for a couple of days later than you should have done then you get it in the neck. There is no valid reason for that, it is not based on people's needs."
>
> **Social worker 4, PAM 2**

Box 13.3
Policy allaying public concern in conflict with practice

Some expressed concern that central government policy was dictating both the context and focus for clinical practice. A number of CMHNs and psychiatrists saw Supervised Discharge, the Supervision Register and CPA as an outside interference with their clinical work with little intrinsic clinical merit. Social workers in CMHT A and in the

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[133] This may have reflected the different socio-economic profile of users covered by CMHT B, compared to CMHT A which covered a more ethnically mixed and poorer population and therefore tended to deal with fewer MDOs and people with long-standing psychotic disorders

[134] See Chapter 10, Section 10.2c

[135] See for example, Chapter 12, Section 12.b , Box 12.7a

group interview criticised the thrust of policy towards the 'policing' of the user as part of a 'defensive' and 'political' approach to mental health care.

The national policy focus on SMI was seen by a number of clinicians positively because it was felt to define the role and remit of the CMHT, though some recognised that it could cause difficulties in terms of its operationalisation (See Box 13.4). On the other hand some clinicians, for example the clinical assistant from CMHT A, did express concern about the consequences of the focus on SMI in terms of its impact on caring for people with non-SMI problems and one that it contradicted the general philosophy of the NHS in providing comprehensive care.

"Well, I think we are, in some ways, fortunate that Government policy does dictate priorities with the long-term mentally ill. So I think in some ways, it's not necessarily for us, particularly, to resolve, 'cause I think that GPs can't just say to us: 'Well, we just want to purchase counselling. We're not interested in people with schizophrenia', because I think that clearly there are external Department of Health directives, which stop them doing that. So I think at least in some ways, we do have at least some external protection."

Consultant psychiatrist 1

"I think one of the issues that sort of health care is facing is the fact that we can't meet everybody's needs and that at some point we are almost having to go for what is good for the general population rather than the individual yet we are very much caring for the individual at an individual level."

CMHN 7, PAM 1

During the tea break discussion amongst team members centred around the increase in workload to make up for resource shortages. One CMHN said he wished that the NHS would 'get honest' about rationing'. Another said that patients were expecting too much in relation to what could be delivered.

Observation of CMHT B tea break during team meeting

Box 13.4
The focus on SMI

Amongst some, positive views of the policy not only seemed derived from a view that it protected the CMHT remit but also from a general consensus promulgated by the Government and in the academic literature that people with SMI had in the past been neglected by services compared to other groups and should be focused upon.[136] Complimentary to this perception was the belief that limited resources inevitably meant

[136] See Chapter 2, Section 2.3, Chapter 3, Section 3.1a

that the CMHT could not care for all people with psychological problems and needed to focus on those deemed greatest in need.

These views also seem to be generalised to other teams in the Trust as group interviewees mentioned it. This view was also occasionally declared within the CMHT meetings (See Box 13.4). Bearing in mind the attitudes of some managers towards SMI[137] in which criticism was made of the policy in terms of a fair distribution of resources relating to the provision of support for non-SMI patients such perspectives are interesting differentiation between the respective groups.

13.1(d) Commissioning policy and resource reductions

Most respondents, including the clinical team leader of CMHT A, said they knew very little about the commissioning intentions and contracts negotiated between the commissioners and the Trust. Only two respondents expressed an awareness of the Government's demand that the DHA reduce spending for that year.[138]

A number of clinicians discussed the local impact of resource reductions, seeing policy responsibility through a local rather than national prism. This may well have been because of the impact such reductions had on their own practice. Of particular concern was the closure of a day hospital and, whilst observing CMHT B, the experience of the loss due to financial reductions of an occupational therapist only two weeks after she had joined the team. The restrictions on referrals to specialist services[139] were also raised as an issue both at interview and in observed team meetings.

Generally these restrictions were seen as a negative development partly because a number of clinicians felt they were imposed without regard to their views and because of the general impact they would have on delivering services. A number felt that the DHA was able to impose them because they relied on the CMHT to absorb the clinical consequences.

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[137] See Chapter 10, Section 10.2d
[138] See Chapter 8, Section 8.3
[139] See Chapter 8, Section 8.3a

Some clinicians linked their resentment of resource policy with the position it placed them professionally when dealing with affected users. Indeed their clinical response seemed to reflect Lipsky's (1980) view that street level bureaucrats consciously engage in behaviour that disguises resource constraints and reductions through managing the impact on the user affected (See Box 13.5).

"Well, I find it very difficult to not er to be objective. Because I feel very strongly that [DAY HOSPITAL NAME] should not have closed. And it's often just about listening to somebody and for me... kind of explaining the inevitability of the distress of losing something that's been important to somebody."

Occupational therapist 1

"More recently, for example, when the health authority went into financial difficulties and there was a directive from management to, I mean there were no funds, for example for [LA1] referrals after August or so I still see clients when it is a relevant kind of referral. And I have to avoid it. And I see it as an example of change in the pattern almost as if I was waiting for the new financial year to start so we can refer."

"I if I don't point out to the family that this could help the patient, the family doesn't know that is what they have not had and I find myself occasionally not mentioning it even though I might have thought it is something that would help."

Clinical assistant

Box 13.5
Disguising the impact of policy

With regard the commissioning influence of GP fundholders CMHT A clinicians appeared more negative than those from CMHT B. This difference may be due to the smaller number of GP fundholders dealt with by CMHT A. The majority of GPs dealt with by CMHT B were fundholders and included the TPP.[140] This meant that CMHT B was perhaps more habituated to the commissioning influence that GP fundholders exercised.

All the clinicians who raised the issue of GPs, with the exception of CON2, said that Trust managers emphasised the importance of satisfying their needs, particularly fundholders. CON2 stated that he was conscious not to give preferential treatment to referrals from GP fundholders compared to referrals from non-fundholders. However, this seemed to be contradicted by other members of CMHT B who felt that fundholder referrals were dealt with rigorously and more sympathetically compared with those

[140] See Chapter 5, Section 5.4a

from other sources. This perception also received some confirmation from the comments of OPM2.[141]

13.1(e) Concluding comments – clinical subordination

It appears that a number of clinicians viewed much policy negatively. Discontent was mostly criticism of specific local decisions, though there was a view, couched in macro terms, expressed by one or two that too much was being expected of CMHTs, with an implication that the 'much' needed to be reduced. Hence the general support voiced for the focus on SMI, though with the occasional concern voiced for the integrity of practice in relation to comprehensive care.

The thrust of national and local policy was seen by some as politically driven and not aimed to support clinicians. Evidence of this was seen in non-consultation, changes to the context and requirements of practice or through requiring the CMHT clinician to absorb the consequences of resource reductions. Thus the policy signal as interpreted by a number of clinicians it could be argued was one that emphasised their subordination to policy.

13.2 The CMHT/ management interface – communicating policy

Lipsky (1980) identifies managers' attempts to ensure that street level bureaucrats make decisions that reflect policy and the street level bureaucrats concern to protect their autonomy and discretion as an important point of implementation tension between the two. The perception of managers' actions in this regard by street level bureaucrats and the relationship of this perception to the reception of policy would appear to be an important aspect of this relationship (See Sections 13.1(b) and c).[142] Indeed, both Gunn (1978) and Allison and Zelikow (1999) identify the communication of policy to implementers and their reception of such communication as a significant influence on the process of implementation because, as Spillane *et al.*, (2002) point out the communication process is one of the principal mediums through which street level bureaucrats identify and interpret policy signals. This section therefore explores the

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[141] See Chapter 11, Section 11.2c
[142] See also Chapter 12, Section 12.3(a)

issue of the relationship of managers and communication as discussed by the members of the CMHTs.

> "I have some reservations. I often feel that management is actually management and not nurse or care management any longer and I think that it is sometimes, I think they don't realise what the realities of working with essentially very sick people over long periods of time can be. I think sometimes decisions are made for financial or research reasons rather than common sense really. I think commonsense is largely missing."
>
> **CMHN 1**
>
> "She [OPM2] hasn't got an insight, she's not a clinician. So therefore she doesn't appreciate the fact that somebody has been working in this field and you can't just shift that person. ... [OPM1] would have. Definitely, definitely. Because this is the first time, in a way, we're having a manager without any clinical experience and it is hard. It is a struggle with her (OPM2), because you don't want to talk to her because she doesn't understand."
>
> **CMHN 5**

Box 13.6
'*Capacity distant* and *Capacity connection*'

13.2(a) Managers' dichotomy of capacity[143]

There was a *'dichotomy of capacity'* with regard the perception held by some of service managers (See Box 13.6). For example, some in CMHT B saw the manager as lacking capacity to appreciate team problems because she was neither a clinician nor did she engage in day-to-day contact with the team. This view of lack of capacity also appeared for some to generalise to the Trust management in general. One could say in these terms that some middle and senior management was seen as *'capacity distant'*. Whilst most in this CMHT did not offer an explanation for such distance CMHN4 felt it was a deliberate insulation from the 'professional issues' associated with policy implementation.[144] This view of management received support in group discussions.

Within CMHT A, CON1 said that there was no tension between the service manager and the CMHT. Neither the other team members nor my observations, however, wholly supported this opinion, though the relationship was considerably less tense than that observed in CMHT B. This difference seemed to be derived from a more regular contact between OPM1 and CMHT A and a generally held perspective both inside and outside

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[143] 'Capacity' is used in relation to two of its meanings which I feel are inter-related in this context – 'the ability to understand or know' and 'a specified position or function' (Collins, 1999).
[144] This view is consistent with more general comments made about the relationship between managers and consultant psychiatrists (See Section 13.1b)

CMHT A that OPM1 had an insight and empathy with clinicians denied to OPM2 because she had a clinical background. One might describe this better relationship as based on a perception of '*capacity connection*' (See Box 13.6).

13.2(b) The service manager as policy conduit

A number of respondents saw the service manager as the conduit and enforcer of policy decisions, feeling that these managers were only concerned with meeting targets. Some complained that the service managers could be quite intimidating in relation to these targets, requiring explanations of clinicians when they did not meet their contact targets. However, the tension between CMHT B and its service manager seemed to be of a more generalised nature than that with CMHT A, in the latter case tension appeared to arise only over specific issues (See Box 13.6).

13.2(c) Avenues of communication

The CMHT business meeting was the most regularly cited source of information and the primary avenue through which most clinicians heard about policy, usually communicated to them by either the service manager or clinical team leader. Alternatively, some mentioned as a source of information printed media. For example, CON1 mentioned the quarterly performance report[145] to which he had access but which, he noted, made very little sense to him. Others mentioned various *ad hoc* audit reports and memos and Department of Health circulars they received, though some complained of an information overload leading from sources leading them to them ignore most of this material.

13.2(d) Filtered policy information

A number of respondents felt that the information they received from Trust management about policy issues was vague or 'filtered'. There was a suspicion amongst some that the clinical team leaders received privileged information denied to others in the CMHTs.[146]

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[145] See Chapter 5, Section 5.5b

[146] This also connects with the general suspicion surrounding the nature of the relationship between management and consultants.

Interestingly, there was a difference of view between the two team leaders about how well informed they felt the Trust kept them about policy. CON1 only felt well informed about the contractual and policy requirements relating to GP fundholders in his locality, but that he was poorly informed by the Trust about wider policy issues. CON2, however, felt that the Trust kept him well informed through regular meetings with the Clinical Director of Adult Services, though he believed the Trust was poor at communicating with other CMHT professionals.

CON2, along with some others, felt the generally vague way in which information was communicated or not communicated by the Trust had certain advantages for management in that it meant teams were less likely to challenge or make demands of managers. Therefore it was in the interests of managers not to communicate more than they perceived as necessary. Alternatively lack of effective communication, as PSYCH1 pointed out, could work against the interests of management by creating a sense of resentment and suspicion leading, in her view, to secretiveness and passive non-co-operation with management agendas.

13.2(e) Communicating policy implementation to managers

Management's perceived need for information was an important cause of resentment amongst many members of both CMHTs and in the group interviews, though it was particularly cited within CMHT A. These resentments focused on the perception that staff performance was judged on the basis of information returns that failed to convey a comprehensive picture of clinical activity and that much information recording was burdensome, appeared of little relevance to practice and distracted from patient care.

However, a number of clinicians said they felt they had to record such information as proof that they followed policy and as a contingency defence in case of an untoward incident. One respondent admitted that her fear of not meeting contact targets meant that on occasion she had filed false information returns as a consequence of this 'fearful' mindset (See Box 13.7).

"I think the pressure now is making sure you have got the right paper work for everything and it seems as if there is almost more, more of a pressure to have the paper work available then you actually seeing the client."

Social worker 1

"Em, because, I will always put in that I've seen a client for an hour, even if I've only seen them for half an hour. ... Something which I will do, which is quite naughty, is if they cancel, there's no way - that doesn't come up in the information system. So it doesn't come up as a face-to-face contact. So, if they cancel, sometimes I will put in that I've seen them for half an hour ! It's really bad, isn't it ?! Because I don't want my caseload - I don't want them to see that, actually, three people have cancelled today, which happens occasionally, and that I've had only two face-to-face contacts. I don't want them to know that. So I will put in, sometimes, not for all of them, but sometimes I put in that I've seen the cancelled person for thirty minutes."

(N.B. I decided not to identify by even by code the respondent who said this in order to further enhance their anonymity)

Box 13.7
'Defensive' recording returns

13.2(f) Concluding comments – communicating distrust

It would appear that the overall attitude to communicating information on implementation to management was seen not as a participatory activity of clinical care, but rather an imposition on clinical practice to meet an agenda considered antithetical to that of clinicians. The general hostility to information systems within the Trust highlights both the failure of Trust policy to convince clinicians that such information was a legitimate part of practice,[147] whilst also calling into question the veracity of the returns filed. Indeed, overall the hostility towards information and its communication on the part of a number of clinicians indicates the degree to which managers and the policy agenda behind were distrusted.

Indeed, during discussions in PAM1 information returns on clinical contacts and managers' perceived faith in their veracity was mentioned which prompted general tittering within the group, perhaps indicating that many recognised that not everyone sent in true data.

[147] See Chapter 9, Section 9.3

13.3 Policy behaviour – atmosphere and implementation dissonance

A number of clinicians both in the group interviews and individually described their attitude and compliance with policy as arising out of a sense that the policies promulgated at national and local level were a *fait accompli*. This did not necessarily mean that clinicians either agreed with or were willing implementers of policy. Some respondents spoke of an atmosphere of general discontent with Trust policy requirements and pressures manifested and perhaps reinforced through discussion between team members. This was sometimes observed (See Box 13.8). This discontent sometimes seemed to arise from a combination of a sense of being asked to engage in what were seen as clinically distracting activity such as information giving to management and a sense that policy lacked a 'cultural' empathy with practice values. In both teams policy implementation appeared to be affected by such *discontented atmospherics of practice*.

> "I think one of the advantages of this kind of team work is that you talk to other colleagues, it is a most helpful aspect of team work and of being in the same base and as I was saying sometimes you might have paperwork and you might have a deadline but if you are feeling kind of unhappy and if there was an opportunity getting it off your chest, I mean if there were a group of people going on about it and you could join them then you would take that opportunity. I think there is by far the most valuable way of doing that"
>
> **Clinical assistant**
>
> *The clinical auditor comments that a number of people have said to her that a care plan is just a lot of bureaucracy. However she disagrees and says she thinks a care plan can help in delivering patient's care. SW1 says that is right but the question of balance is important because it can distract from doing other things.*
>
> **Observation of discussion during tea break between Long-term case register auditor and members of CMHT A**

Box 13.8
Discontented atmospherics

13.3(a) Interpreting importance – immediacy of implementation emphasis

Some clinicians said they felt they had to implement policy when personally told to do so by management, either in terms of a written instruction or face-to-face contact. The emphasis on information returns and monitoring was also said by some to indicate the degree of importance accorded to a policy by management and that this too would influence their decision on what to prioritise for implementation.

This may explain in part why compliance with CPA was not complete in both teams - though in the case of CMHT B considerably poorer than that of CMHT A – as CPA compliance was monitored annually and tended to be examined with reference to team rather than individual compliance and therefore accountability. In terms of explaining the comparative differential of CPA compliance between CMHT A and B there appear to be two variables in relation to monitoring. The first is that the clinical team leader appeared more willing to expose an individual's caseload within the team environment to scrutiny.[148]

> "I think it does some of our clients - you could argue whether it's fifty or a hundred or three hundred - do definitely benefit from the CPA process. The CPA. process is essential for them. It's very valuable. People are at peril that haven't got the process. But it's a complete nonsense just if someone comes to see me in out-patients, once every three months or once every six weeks, who sees any discipline needs a C.P.A.. The problem is that it turns into a very big task, which is devalued."
>
> **Consultant psychiatrist 2**

Box 13.9
Discriminating implementation

Secondly, the commitment to implementing CPA on the part of CON2, the clinical team leader, appears open to question in terms of his view of the application of CPA (See Box 13.9) and his own poor attendance of the CPA review meetings, which he had initiated. It could be argued that he 'discriminated' in relation to his implementation of this policy.

Associated with this 'immediacy' emphasis was a fear expressed by some of consequence if one was seen not to implement. Consequence depended upon the nature of the policy issue at hand. For example in relation to a nationally related policy, such as a focus on SMI, OT1 speculated that ultimately management would threaten her with dismissal if she refused to comply with meeting caseload targets after having received a personal instruction.

Overall it would appear that the interaction of the extent that managers sought information on implementation, how they instructed clinicians and the fear of

[148] See Chapter 12, Section 12.3b

consequence should one not implement appeared to influence practitioners' implementation of a policy. The ways that non-implementation seemed to manifest itself amongst the case site CMHTs will be addressed next.

13.3(b) Marginal deferral

Meeting policy requirements with regard information returns seems to have been the over-riding policy concern for many respondents in both CMHTs and in the group interviews. Information giving and maintenance of records was also the policy activity about which they made judgements in terms of level of compliance.

Some practitioners seemed to suggest that if they were in control of immediate access to data and they viewed the maintenance of such data as of little use to their immediate needs then it was likely that such policy requirements would not be a priority. Some justified this action by claiming these particular administrative demands distracted from patient care in terms of the time they demanded. Recording implementation of care plans and associated data returns viewed as repetitious sometimes seemed to fall within this area.

" if like sometimes you have a tendency to put something that is not seen as important first, it keeps piling up and those kind of issues have or kind of effect psychologically on what you are doing or what you are working or what you must do and I think eventually to some extent it does have implications on your face to face contact with your client."

Clinical assistant

"Care planning takes some priority, but gets down at the bottom of the pile, administratively, because no-one looks at it."

CMHN 4

A large number of patients had a care plan that was very old. She found that 17% of the sample had had their care plan written either two weeks before discharge or one week after discharge.

Observation of CMHT A, business meeting in which CPA auditor is reporting to team on the results of her audit of the team care plans

Box 13.10

Marginal deferral

However, most practitioners appeared not to refuse to comply. Implementation seemed to occur in many cases once a 'tipping point' of anxiety was reached in relation to non-

compliance either in terms of its impact on other work factors or on the likelihood that non-compliance would be exposed through being seen by others. In this sense therefore implementation was deferred (See Box 13.10). A form of *marginal deferral* occurred where non-compliance was seen as safe for short periods of time or where non-compliance was unlikely to be challenged for long periods, for example attendance of some team meetings.[149]

13.3(c) Non-operationalisation of policy at the margins

A number of respondents discussed practitioner reactions to local policy with which they disagreed in terms of sabotaging activities. For example, in CMHT B SR2 said that she refused to enter data on the computer information system, but would send in written returns on the information required. Thus she was implementing policy, returning information, but not through the prescribed format.

This activity was different from marginal deferral in since it appeared that its intention on the part of a few practitioners was not to co-operate with aspects of policy rather than merely defer co-operation. However, there appeared to be no evidence of a direct challenge to management in relation to implementation, that is a statement of refusal. Thus this activity may be seen as lying somewhere short of defiant resistance to policy but nevertheless refusing to operationalise some of it. However, as with deferral, this non-operational attitude occurred at what might be seen as the margin of policy, - its prescribed format rather than policy *per se*.

13.3(d) Discretionary and collusive non-implementation

Policy that relied on clinical discretion in terms of its application and with which the clinician disagreed was unlikely to be implemented (See Box 13.11). There were, however, some indicators that occasionally Trust managers colluded with clinicians in their use of discretion as a means of managing policy pressures and difficulties, for example CPA ambiguities[150] and perhaps as a means of retaining support of key clinicians. Thus CON2 talked about an informal Trust policy that not all patients needed a CPA.

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[149] See Chapter 12, Section 12.3b
[150] See Chapter 2, Section 2.4

"Well, some of the things don't get used. Supervised discharge is probably a good example. I think there was one person within [TRUST name] on supervised discharge. I think it reflects that it's not a good policy. I think that the Care Programme audit that [clinical auditor's name] did show that virtually all the standards were not being met. I think that's probably not because people are inefficient, but because the standards have very little meaning and influence on people's day-to-day lives."

Consultant psychiatrist 1

"Basically, it's [TRUST name] policy, [writing CPA care plans] so you have to. It's government policy. You have to do it."

Q: Except that they're not, are they? Or at least it appears for about forty per cent of the clients.

"Well, again, the reason why... To be honest, [TRUST name] made it very clear that not all the clients that get them need them. But there is an audit, which seems to ignore that!"

Consultant psychiatrist 2

Box 13.11
Discretionary and collusive non-implementation

Official documentation nevertheless indicated that all patients should receive CPA thus perhaps allowing managers to argue that they were attempting to implement policy and maintain that incomplete implementation was as a result of the exercise of clinical discretion. As has already discussed once an issue falls within the perceived remit of clinical expertise it is more difficult for the non-expert to engage in challenge.[151]

13.3(e) Refusing to implement policy

Few respondents said they openly refused to implement policy, unless it was permitted within the context of clinical discretion, though this did not mean that they sometimes didn't articulate disagreement with policy decisions. Challenge when it was made appeared to focus on particular issues for example policies that might lead to an increase in personal workload such as a cut in a service. When some made such challenge they seemed to seek support from colleagues and others, such as their union, however, generally their reluctance to challenge was based upon a fear of that it would affect their employment security should they do so.

[151] See Chapter 5, Section 5.2(f)

There were two groups who seemed both more confident openly to challenge policy with which they disagreed and were prepared to refuse implementation on occasion. In the group interviews, CON3 said that the social workers in his team did not agree with the Trust information system and as a result they avoided inputting data. The social workers interviewed saw their ability to refuse to implement policy as resting on their separate managerial accountability and union representation Alternatively, both psychologists interviewed said they were willing to refuse to implement policy with which they disagreed. However, they said that they would do this because they felt they would easily be able to get work in other organisations.[152]

13.3(f) Managing implementation pressure

Attempting to carry out policy that practitioners prioritised also had a *displacement* impact for some on their work overall (See Table 13.2). As already discussed in Chapter 12,[153] the CMHTs seemed to engage in a process of deferential deflection to manage clinical demand. In effect they interpreted the policy focus on SMI as 'permissiveness not to provide a service'. However, some clinicians also said that they sometimes diluted the quality of the work they did with users they had accepted as a means of managing the pressures that a number felt meeting policy requirements individually sometimes placed upon them (This is a strategy a number of authors, Harrison and Hunter, (1994) and Chisholm and Stewart, (1998, for example, identify as a regular form of micro health care rationing).

The Clinical Assistant in CMHT A, for example, felt that he offered less time to patients in terms of face to face contact because of the pressure of meeting policy requirements in relation to information returns. This appeared to receive some support from the comments of OT1, who said she engaged in the on-going management of much of her caseload via telephone or alternatively spread the time period between direct face-to-face contact. This latter strategy was echoed by SW2, who also reported that he reduced paperwork demands by recording minimal information or not writing up notes until a patient was discharged. CMHN4, in CMHT B speculated that one of the reasons for

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[152] Indeed, of course it should be noted that it was a psychologist who overtly challenged the policy on clinical team leadership in CMHT B, and then left the Trust's employ.
[153] See Chapter 12, Section 12.4

non-attendance of CPA meetings and/or not effectively communicating about users within the CMHT was the desire of some of her colleagues to ensure that they had met their information returns.

Displacing strategies	Permissiveness not to provide a service	Dilution	Brokerage	Criteria manipulation
Sample unit				
CA	1	1	0	0
CON1	1	1	1	0
CON2	1	0	0	0
CMHN 2	1	1	0	0
CMHN 4	0	1	0	0
OT1	0	1	0	1
OT2	1	0	0	1
PSYCH1	0	1	0	0
SR1	1	1	1	0
SR2	1	1	0	0
SW1	1	1	1	1
SW2	0	1	0	0
SW3	1	1	0	0
Medical group	1	1	0	0
PAM1	1	1	0	0
PAM2	0	1	0	0
CMHT A BM	1	1	1	0
CMHT A RM	1	1	1	1
CMHT B TM	1	1	1	0

Table 13.2
Implementation displacement strategies
(1=coded; 0=uncoded)

Some respondents discussed how they could manipulate policy criteria as a means of managing policy pressures to which they were subject. For example, in their anxiety to manage potential risk some said they manipulated statutory criteria and guidelines, so as to reduce the stress to which 'risky' users might be subjected and ensure their

manageability. Others said they manipulated their data returns in terms of, for example, recording 10 minute contacts with users as 30 minute contacts.

13.3(g) Concluding comments – the significance of 'mutuality' of interest in non-implementation

It would appear from the above that non-implementation of policy primarily occurred at a marginal level rather than in terms of overt refusal. Thus policy was resisted in conversation between practitioners and in terms of hindering its implementation; but rarely was it opposed directly. Indeed, it is notable, that the area where one could discern non-implementation arose from a mutual interest between the two implementing groups – managers and clinicians – in relation to full application CPA and the use of Supervised Discharge. It is perhaps worth noting that both these areas were connected to perceived potential sources of tension between these groups in relation to clinical discretion and resource pressures.[154]

Having identified that respondents were unlikely to challenge policy overtly therefore we are left to account for those occasions when this did seem to occur. The notable connection in relation to overt challenge was that this was likely to involve either social workers or psychologists, both of whom in their own way felt independent of the Trust. Thus it would seem that the more one felt independent the more one was likely to challenge, though even here challenge was rare. This lack of challenge seemed in part to arise out of a 'fear' of consequence indicating the affective influence on respondents' decisions in relation to their compliance with the policy environment.

13.4 Practitioner affective alienation within the local policy environment

In Chapter 11, the 'affective' response of a number of managers to policy was identified as an influence on their approach to its implementation.[155] Indeed, it has been pointed out that affective elements can influence <u>what</u> implementing agents respond to in terms of policy (Spillane *et al.*, 2002). Lipsky (1980) sees the management of affect, personal anxiety about policy, as a significant mediator in the street level bureaucrat's decisions about how they implement policy. This section therefore deals with the notable

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[154] See Chapter 11, Section 11.2 and Chapter 12, Section 12.4
[155] Section 11.2,

'affective' elements exhibited by respondents in their discussion of the policy environment in which they practised.

13.4(a) Lack of reward and feeling devalued

A number of respondents said they felt professionally devalued in the eyes of management; particularly in terms of the way they were comparatively valued with the medical staff. As discussed, the policy on clinical team leadership was viewed as confirmation of this view, in terms of the motivations for its implementation and the perception that other clinicians who had opposed it had had to leave the Trust. Alternatively a number of the medical staff also felt devalued, stating that a combination of the complexity of the problems they were now expected to manage and a reduction in autonomy had made their job unattractive.

Some respondents identified a feeling of constant and rapid change as part of the reason for their general sense of being devalued. One respondent (SW1) felt the combination of constant change and non-recognition of professional opinions by management meant that professionals became conditioned not to voice protest.

In a context of feeling devalued credence appeared to be given by some to rumours that validated this view. Thus OT1 told me that that the Clinical Director of Adult Services wanted to remove OTs from CMHTs as he felt they were of little value to clinical practice. When the veracity of this statement was checked after the interview by speaking to the said Clinical Director it was found to be untrue and that no such proposal was under consideration.

13.4(b) Working within a blame and insecure culture

Some respondents said they felt that managers did not appreciate the difficulties with which they had to cope in their work and that they were only ever interested in their practice when there was an untoward incident or in terms of achieving policy targets. The overall policy environment was seen by a number of interviewees as being that of a 'blame culture' in which they felt 'watched' and feared being personally blamed should

a user carry out a violent incident. For example SR1 spoke of a sense of constant threat held over her head by a "fine thread".

Others spoke about monitoring in the context of the potential to lose one's employment. For example a discussion took place in PAM1 on this subject, with one contributor (CMHN7) stating that OPM2 had told her CMHT that if they lost Fundholder contracts the Trust might have to make staff redundant.

This sense of employment insecurity was also discussed in PAM2, where it was stated that one CMHT had had to be disbanded because they had lost fundholder contracts. The fear that one might lose one's job appeared to be confirmed in the interpretation by some of the consequences for staff who had opposed clinical team leadership. When the ADNS was asked whether clinical staff had been made redundant for any of these reasons she said that they had not and that Trust policy was to re-deploy clinical staff whenever possible.[156]

Although monitoring was seen as a negative manifestation of control and threat, some practitioners seemed to be placed in a 'double bind' position between their affective response to monitoring and their intellectual response. Their more 'rational' perspective (and perhaps professional commitment to standards) led them to state that monitoring was important if poor practice was to be identified and clinicians needed to be held to account for this.

A number of respondents talked of the effect their general anxiety in meeting policy requirements and fear of blame had upon them in terms of their practice and sense of employment security.[157] Some reported feeling compromised between their view of their professional standards and the implementation of policy as a result (See Box 13.12).

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[156] Indeed the staff who had opposed clinical team leadership in CMHT B had not been dismissed from their posts but had found alternative positions in other Trusts and left for these. Whilst two CMHNs in CMHT B had been re-deployed to the CMHT from a day hospital that had been closed down.
[157] See for example, Chapter 12, Section 12.3d

"Sometimes, you wonder what this job's about! Because it is a lot about responding to - You know, how much do I have to do legitimately, in order to not get shat on? And how much of this job is about looking after people? It's terrible!"

"I think that there are very powerful people who could make it very, very difficult for me to carry on in my job. I don't want to be stigmatised and I don't want to not get other jobs because of Big Brother. You know, I think, at the end of the day, that's what it's about. It's about how much do I compromise myself professionally in order that I can still remain sane in my job? And it is a compromise, because equally, this could drive me insane! (Laughs.) You know, that kind of thing. Where do you draw the line between the compromises you're making?"

Occupational therapist 1

Box 13.12
Feeling 'compromised'

13.4(c) Concluding comments - insecurity and 'fearfulness'

Hargreaves *et al.*, (2002) point to the emotional conflict that arises for implementers when they see change as in conflict with their own goals or where they see policy change as not making sense. Alternatively, they identify that when implementers feel that they initiate change their emotional response to policy is more positive. Huberman and Miles (1984) identify that emotional reactions on the part of actors to the policy environment focuses attention on particular aspects of implementation or leads them to abandon attempts at implementation altogether.

It appears that a number of practitioners affectively interpreted policy signals in terms of personal threat in relation to their implementation rather than in terms of the broad policy goals.[158] As such their anxiety was derived from a fear of being identified as failing to implement combined with a sense of anger from feeling devalued and relatively powerless to influence that for which they would be held responsible. At the same time, in the case of some, their emotional reaction conflicted with their rational sense that accountability for practice was important. The combined result it could be argued was that implementation took place in relation to that for which one would be held personally responsible out of fear rationalised through a sense of accountability. In this one may see a combination of the 'affective' with the 'cognitive' as the spur to action.

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[158] This in itself may go some way to explain the general alienation from the organisation reported in the staff attitude survey commissioned by the Trust in 1995 (See Chapter 9, Section 9.2b).

13.5 Internalising policy values –schemata as a point of implementation reference

As indicated in Chapters 2, 3 and 4 an aim of government in relation to health care in general in the UK during the 1980s and 1990s appears to have been to influence the way clinicians conceptualised their relationship with patients so as to take more account of policy and resource considerations in the delivery of health care; in other words to re-orientate clinicians' cognitive schemata, particularly in relation to a more 'economic' perspective in their view of the clinician/patient relationship. This section examines the degree to which this agenda played a part in clinical thinking.

13.5(a) Efficiency as competence

A number of respondents appeared to conflate the concept of efficiency, that is achieving a goal at minimum cost, with effectiveness and professional competency. For example, CON2 saw his primary role in terms of managing the relationship between clinical and resource management. This efficiency related attitude might also be discerned in clinicians' complaints about inappropriate referrals to the CMHT[159] and in their cognisance of the comparatives they made with colleagues about the use of their clinical time.

13.5(b) The importance of providing evidence

Some respondents said that professional opinion alone was no longer sufficient to justify a treatment course, but had to be supported by evidence. This was connected to the advantages of audit as a means of improving practice and providing a chance for clinicians to assess their own skills in their management of users. Others spoke of information returns as providing evidence of implementation to commissioners (See Box 13.13).

This view may seem to contradict the negative view of information policy and its implementation described earlier (See Section 13.3b). However, this can be reconciled through a recognition that resentment of information policy was derived from a view that what was demanded imposed an undue burden upon clinicians in relation to their view of the utility of what was demanded. As such their implementation response could

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[159] See for example, Chapter 12, Section 12.4b

be seen as in part 'affective' (See Section 13.4c), where the principle was not in question but rather the specific demands and operationalisation (See Box 13.13).

"Of course there are minimum standards. This is why they are very important to be established and monitored because otherwise it is difficult to know if you are doing good enough work with the client group."

Clinical assistant

"I see the purpose of information, as far as management are concerned, to give information to the purchasers, because the purchasers demand it. And to keep an eye on the fact that we are fulfilling our standards. Now there is - I can see some sense in that in some way. In that, obviously, if people are, er. Then you get into performance and things like that and I hate looking at - I hate a tthat kind of thing because I think again, that's really - It's about being critical of people and it's not about nurturing people, or looking at what their training issues are, or things like that. But,er, Yes, they don't look at, for example, what role you do. They don't look at what quality of work you do with people. For all they know, I could just sit in a room with somebody for an hour and not say anything. I don't know how you measure that and I don't think it should be measured. But I think that looking at quantity does not provide an effective or reliable way of looking at the kind of work we do. And if they want me just to sit in a room with somebody every twenty minutes, that's fine."

Occupational therapist 1

" the information is incomplete. The system asks us to give incomplete information that is how I feel about it and they use it for their statistics. You know that is how it is. So in a sense it is very incomplete and it costs you a lot of time."

Psychologist 2, PAM 2

Box 13.13

The utility of evidence

A number of clinicians from all professional groups spoke of the need to inform managers about clinical activity and target achievement as proof of one's clinical competence. The fact that some clinicians described how they manipulated data returns so that it appeared that they were meeting Trust targets serves to indicate the degree to which practitioners had internalised the importance of target achievement within practice (See Section 13.2(e) and Box 13.7). Indeed, no clinicians spoke of openly refusing to meet targets, whether or not they agreed with them.

13.5(c) Internalising 'Economic Man'

A number of respondents in both CMHTs and the group interviews either reported that cost now played a part in their concept of practice or alternatively its influence could be seen in the way they talked about service provision (See for example the clinical

assistant, Box 13.5), behaved in meetings and utilised the concept of 'finite resources' to assist in justifying their approach to demand management and their view that CMHT's remit was to 'prioritise' SMI demand because of finite resources (See for example above Section 13.1c).[160] The importance of efficiency and evidence in practice also emphasised this more 'economic' outlook.

"I mean, we've got a set of managers whose job is to balance the budget. If they didn't balance the budget, they wouldn't be managers. Ultimately, they'd lose their jobs. They have to, just like everyone has to balance their bank account at home. These people are paid to balance the Trust budget. A successful trust is a balanced budget."

Consultant psychiatrist 2

"I think one of the issues that sort of health care is facing is the fact that we can't meet everybody's needs and that at some point we are almost having to go for what is good for the general population rather than the individual yet we are very much caring for the individual at an individual level"

CMHN 7, PAM1

Box 13.14

Changing practice thinking

Thus some clinicians appeared to demonstrate a schemata that had moved or was moving from thinking of the connection between clinician and user as an individual relationship to one that emphasised a relationship between the clinician and the wider user population (See Box 13.14). In this sense therefore 'Economic Man'[161] was a feature of clinical thinking and action (See figure 13.1).

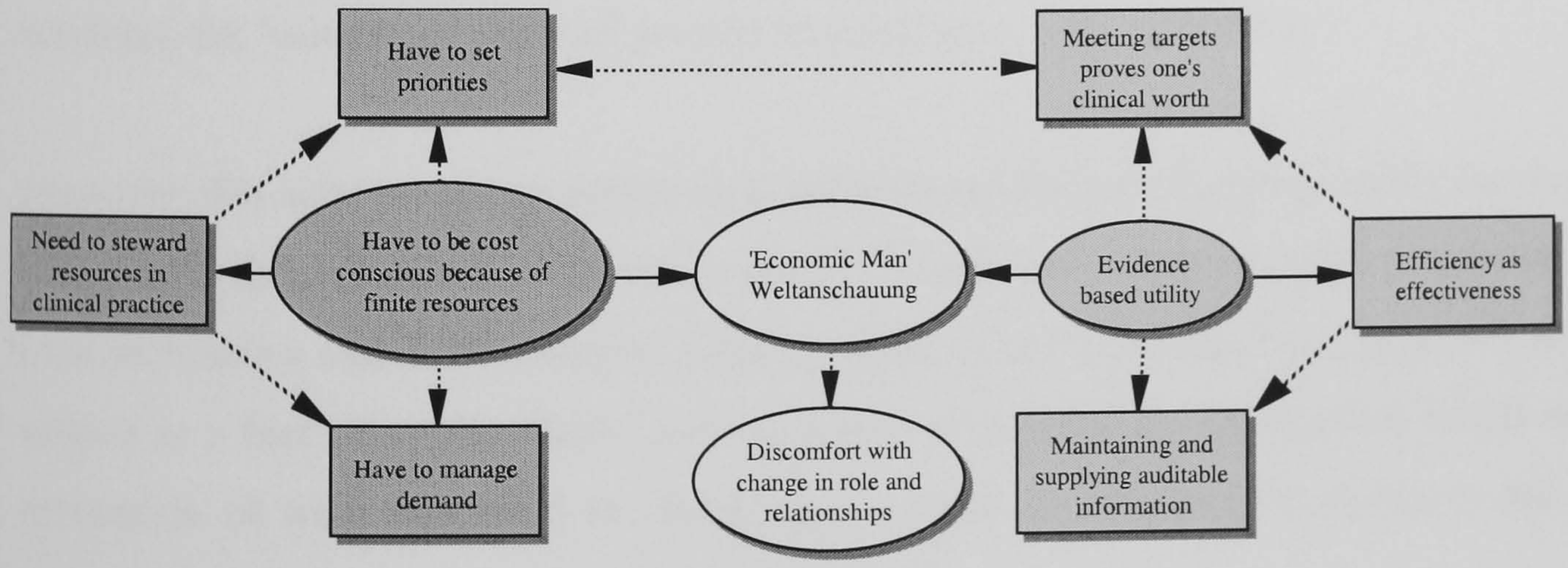

Figure 13.1
Internalised 'Economic Man' as demonstrated by a number of respondents

[160] See also Chapter 12, Sections 12.4a, 12.4b
[161] See Chapter 4, Section 4.4

Whilst 'Economic Man' was incorporated into the practice thinking and action of a number of clinicians within the case site, not all practitioners felt comfortable with it. These individuals seemed concerned with the impact such factors as cost consciousness had on the way they felt about what they had to do as part of their practice and the professional satisfaction they derived from their work (See Box 13.15). However, even those who spoke of their discomfort only spoke in particular terms and did not question the overall 'rightness' that such an 'economic' framework should play in practise.[162]

> You know that. I have to think to myself: now, this person needs a service, but how's the money going to be collected. Because I've had that situation occur before where a person stopped failing to pay their stamp, yeah? Then the problem was flagged up to me and I speak to the person. They pay for a little while and the problem starts again. It's very annoying, 'cause I thought: I'm not a debt collector, but that's what it feels the role has been pushed into."
>
> **CMHN 2**

Box 13.15
Discomfort with the 'economics of practice'

13.5(d) 'Risk' and 'risk to self'

Clinicians' focus on SMI and their consciousness of the management of behaviour of users living in the community[163] appears to indicate that practitioners had internalised a focus on 'risk'. One may see this in relation to a number of clinicians' admission that users without this community aspect of danger were not a priority and, in the case of transient disorders were an 'illegitimate' drain on the focus of the CMHT as a resource.[164] Thus dangerousness and the emphasis on risk containment served to reinforce the 'economic' view of priority in relation to finite resources.

However, this schema of risk appeared in some instances to influence practice decisions with regard the risk posed to the self-interest of individual clinicians rather than only be located within a care and treatment domain. 'Risk to self' (See fig. 13.2) appeared to be related to a fear of public blame and insecurity in relation to employment based on a perception of what happened to clinicians in instances of untoward incidents and an

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[162] Though one, the clinical assistant pointed to the philosophical problems of focus in relation to a commitment to a comprehensive health system.
[163] See also Chapter 12, Section 12
[164] This also connects with Fisher's (1998) heuristic of 'deservingness' described in Chapter 5, Section 5.1.

interpretation of the circumstances surrounding the departure from the Trust of particular clinicians (See Section 13.4b). This in itself it could be argued was a result of the greater emphasis on a community rather than individual orientation of clinical responsibility, and related to the schemata of 'economic man'.

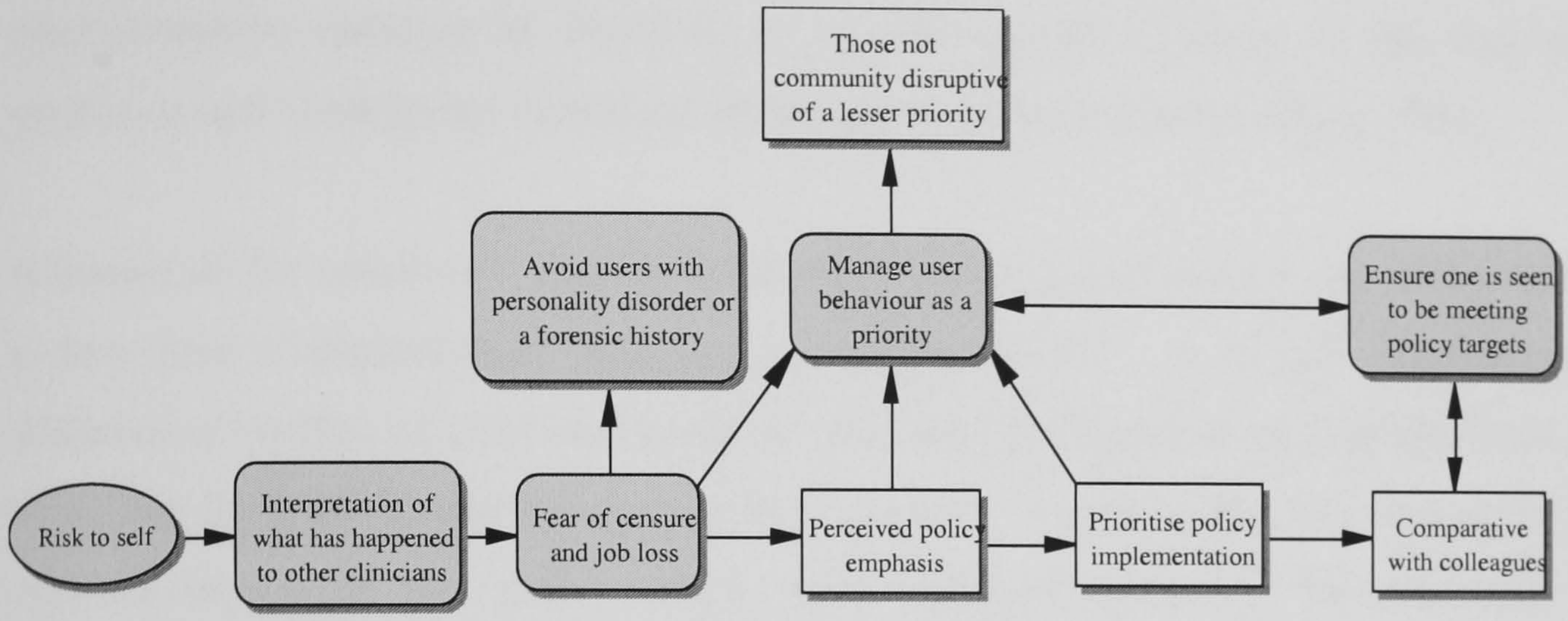

Figure 13.2
Schema of 'risk to self'

Thus practice decisions for some became in part a calculation of personal costs and self-interest (See for example Sections 13.3(a) and 13.3(b) above).[165] For example, SR1 mentioned that she felt obliged to consider in her calculation of how much clinical time she should allocate to a user the degree to which they could create problems in the community, "Because if they feel they are not getting enough in put then they are going to need to generate more crises and draw in more people. So it is very difficult to ignore these people".

One can comparatively view SR1's observation with that of her social worker colleague (SW1) who said that he kept users on his caseload who he thought might have a potential to cause trouble for him through their behaviour in the community.[166] This community orientation of risk also serves to explain why some practitioners were

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[165] See also Chapter 12, Section 12.3d
[166] See Chapter 12, Section 12.3(d), Box 12.18.

reluctant individually to be responsible for users with a forensic history[167] because of the fear of community opprobrium should the user offend further (See also Section 13.4b).

We thus see in operation an example of the combination of the affective - fear and insecurity - with the cognitive - a consciousness of risk - in orientating the implementation attention of clinicians to certain aspects of policy. In this case risk prediction and contingency behaviour management (Huberman and Miles, 1984).

A feature of this schema of 'risk' as it related to personal self-interest and policy seems to have been a calculation of 'adequacy of implementation'. As already described and discussed a number of clinicians spoke of how they managed competing demands on theirs and the CMHTs clinical time within a context of feeling that they needed to be seen to implement that policy which Trust managers appeared to emphasise as important.[168] Informing the decisions of some it appeared was the likelihood of personal exposure in relation to their lack of implementation and whether they had control over such exposure. The implementing decisions of a number of clinicians with regard to some policies seemed to be informed by an assessment of the minimum level of compliance necessary to avoid management censure rather than a wholehearted commitment to implementation (See for example Sections 13.3a and b). Thus they seemed to employ a heuristic that involved a calculation of *adequacy of implementation* in relation to work demands versus personal risk of censure for not fully implementing.

13.5(e) Concluding comments – 'degree of dominance'

Implementation studies have been criticised for failing to explicate the relationship between belief about policy and policy action (Bressers *et al.*, 2000). The 'schema' outlined above would appear to assist in understanding this relationship with regard a number of the clinicians operating within both CMHTs in this study. Two significant but inter-related schema – 'economic man' and 'risk' appear to have been employed by a number of clinicians in their interpretation and implementation of policy. Both related to the individual's interpretation and implementation calculation in terms of personal

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[167] See Chapter 12, Section 12.3d
[168] See Chapter 12, Section 12.4 and Section 13.3

cost, whilst also providing the basis for justification of their implementing action. This does not mean that they replaced other schema, such as a belief in 'caring' or dedication to professional standards. The fact, for example that some clinicians felt uncomfortable operating in an economic way or complained about a reduction in their professional autonomy indicates this. The issue is one of 'degree'. An examination of the opinions of many practitioners would seem to indicate that these two schema and particularly that of 'risk to self' were becoming increasingly the lens through which policy and its implementation was considered.

13.6 Conclusion

Spillane *et al.* (2002) point out that implementers' actions are affected by the interaction of their pre-established knowledge and frames of reference with their situation and policy signals. In this respect pre-established knowledge and ways of 'doing' were seen to be under threat through a perception that the situation of the clinician was precarious in terms of employment, blame and policy which emphasised a focus on managing user behaviour, economically.

Lipsky (1980) argues that street level bureaucrats often engage in strategies to manage their anxiety consequent of the structures in which they work. Certainly the analysis of this data would seem to support his contention. However, as has been discussed, others have argued that street level bureaucrat's decisions are also predicated on an attempt to balance or assimilate multifarious and competing pressures and personally emergent goals.[169] The data and analysis would also appear to support this view.

The incorporation of 'economic' constructions into the CMHTs' approach to care and policy implementation moved individual clinicians' thinking from one where they constructed their clinical relationship as a bipartisan one - between clinician and user – to a more complex tri-partite construction of clinician, user and community; the latter incorporating the other members of the CMHT, clinical agencies external to the CMHT, the Trust management and the wider society beyond the organisation. Personal risk in relation to implementing decisions was then constructed on the basis of which group

[169] See Chapter 5, Section 5,2g

would interface with the clinician and CMHT, the degree and the 'emergent goals' each had in relation to these audiences, for example personal satisfaction in clinical work or being seen to meet targets.

Overall, it can be argued that some clinicians appear to have internalised a policy construction of clinical service delivery in relation to resources and risk.[170] Their '*weltanschauung*' thus defined their clinical constructions through the prism of '*economic man'* and their policy understanding and implementation through the prism of *personal risk*.

[170] See Chapter 2, Section 2.1 and Chapter 4, Section 4.4

CHAPTER FOURTEEN

Comparative Analysis, Critique And Conclusions

14.0 Introduction

Sabatier (1999) states that policy process is possessed of an extremely complex collection of interacting variables that necessarily need to be simplified. This procedure of simplification is necessary if a comprehensible narrative of both policy process and analysis is to be presented. This Chapter is part of this procedure of *complexity reduction*. It presents a comparative analysis and discussion of managers' and CMHT clinicians' approach to policy and its implementation. The Chapter will discuss the overall contribution of this study to an understanding of the implementation of mental health policy and identify the study's strengths and weaknesses that the reader may need to take into account when assessing its credibility and transferability.

Section 14.1 presents a comparative analysis of the findings as they relate to the overall research questions outlined in Chapter 5, Section 5.4. Whilst discussing the differences between groups and individuals it identifies the notion of 'sufficiency' as a link concept, which may help to explain what these groups had in common in their approach to policy implementation. Section 14.2 goes on to explore these results within the context of past and present literature on mental health policy implementation, particularly as it relates to the UK situation, as a means of assessing the study's credibility and transferability.

In Section 14.3 methodological issues pertaining to the study are addressed. Section 14.4 suggests areas for further investigation whilst Section 14.5 presents the overall conclusion to the study highlighting its contribution to the mental health policy literature.

14.1 Comparative analysis and conclusions

Handy (1988) states that the role of the social scientist is to explicate the particular to the general condition of society. Ayres *et al.*, (2003) argues that the strength of qualitative research is that it enables the exploration of the unique whilst providing a vehicle to relate that unique experience to a common phenomenon. The previous chapters have explicated the individual experience and connected these to interpretations of the respective group phenomena. This section proposes a comparative analysis of the identified group phenomenon as a means of addressing the exhortation of both Handy (1988) and Ayres *et al.*, (2003).

14.1(a) Policy cognisance and promulgation

Both managers and clinicians were cognisant of a similar range of national and local policies and displayed, in a number of cases, similar concerns. Thus both groups discussed their concerns with policy on GP fundholding distracting from the national policy focus on users with SMI; or the consequences of the local policy on clinical team leadership.

Some managers' view that national policy alienated staff because of the manner in which it was promulgated and imposed, taking little account of factors particular to mental health, was also reflected by the comments of a number of the clinicians in the CMHTs. However, whereas a number of managers tended to blame Government for this policy alienation, some clinicians seemed to see the way such policies were introduced and monitored in the Trust by management as the more powerful alienating factor. Two examples will serve to illustrate the point.

Clinicians saw the focus on SMI as important and, despite one or two stated concerns[171], agreed with the policy. However a number viewed the Trust emphasis on SMI through the setting of personal targets for caseloads and contact hours as a negative and alienating factor within the policy. A number of them complained that the focus was on meeting these targets and took little account of their practice difficulties and the content of their work. Thus clinicians echoed the criticisms managers made of policy

[171] See Chapter 13, Section 13.1(c) and Box 13.3

but tended to blame management rather than Government prescription for this state of affairs. The response was that some clinicians admitted to 'gaming' the information system and in the case of one respondent lying in terms of some of the data that he/she returned to Trust management so as to appear to be meeting these targets.

GP fundholding was also identified by clinicians as causing a problem with regard distracting their attention from SMI. However, they appeared to see this problem as emanating not from the contradiction of central policy (the view of most managers) but from a combination of GP referral of the 'inappropriate patient' and their perception that the Trust saw the needs of GP fundholders as particularly important to meet. This policy was signalled to the CMHTs through policy requirements to maintain contact and regular updating of GPs and in terms of personal statements by the service managers to the CMHTs.

An important signifier of policy emphasis to both managers and clinicians was the degree to which a policy's implementation was required to be reported upon or subject to a public scrutiny. It would appear that both managers and clinicians viewed this as one of the criteria for prioritising the implementation of policy. For example, the policy priority accorded to SMI, the Patient's Charter standards, and CPA each reflected the degree to which the Trust was required to report to the DHA commissioners on achievement of targets set out in the core quality standards.

CPA received its policy emphasis in the Trust through the annual audit and report of the long-term case register[172]. This indicated to clinicians that it was a priority for implementation, but the degree was clearly qualified since CMHTs were not required to report regularly on its implementation in information returns. Indeed, as we have seen both managers and clinicians reported that there was an informal agreement that it would not be universally applied. In this sense policy could be distinguished in the words of DHAC1 between 'corporate' and 'practice' implementation.

[172] At the time of data collection with CMHT A, the team was undergoing this audit.

Controlling the flow and content of information between stakeholders was also an important mechanism for influencing both the perception of policy implementation and the local policy agenda. In this regard a position of dominance was exercised by Trust management through the reliance of the commissioners on the expertise of significant Trust clinicians (some of whom had a national profile of expertise) for advice and the supply of implementation data.

However, Trust managers were also in a position of information dependency in relation to clinicians who, in some cases it appears, consciously exploited this position so as to appear to be implementing and achieving policy targets when in fact they were only doing so in a limited way and sometimes not at all. In this sense one might argue that these clinicians occupied a policy boundary spanning role in which they acted as information gate-keepers, as Lipsky (1980) argues, controlling management's perception of implementation effectiveness.

An interesting aspect to emerge about the manner in which policy was promulgated in the case site was the degree to which dissemination relied on informal information exchange and face-to-face contact within a context of empathic 'trust'. The recognition by a number of managers of both the conscious exploitation of these relationships of information dependency and the fact that formal information did not always convey a comprehensive 'picture' of implementation at 'street level', may serve to provide an insight as to why personal and informal contact was so valued.

The emphasis on personal contact between commissioners and Trust managers and the face-to-face contact between service managers and the CMHTs was a factor in both mollifying implementing difficulties and exacerbating them. Associated with this was the degree to which a relationship had existed at both the organisational and individual level over time, coupled with credibility of individual empathic status as perceived by those affected by policy.

Thus the CEO and the DHA chief executive for commissioning engaged in face-to-face policy formulation and promulgation because of their history of previous related

capacity, which seemed to serve to diffuse tensions when resources were strained (though it caused tension with the DCEO). At the 'street' level, a number of clinicians in the CMHTs though holding negative views of Trust management overall, felt they had positive relations at a face to face level with service managers who had a clinical background. This in part, for example,, explains the hostility towards OPM2 by members of CMHT B because of what was seen as her lack of empathic clinical background.

Lipsky's (1980) characterisation of relationships between management and street level bureaucrats as 'antagonistic' only appears to be partially supported in this case, in that Trust management at the more abstract level was viewed negatively and seen as 'the other side' by a number of clinicians. The fact that clinicians could put names to many of the senior managers and recognise their clinical background appears not to have affected this abstraction, because they lacked a day-to-day and personal identity in their minds.

However, at the more personal face-to-face level, the relationship appears more complex, particularly where it is felt that managers have a sympathy/ empathy for some of the implementation pressures to which clinicians felt subject. This 'personal' aspect is something Lipsky (1980) does not really take account of in its effect on the climate of implementation and the degree managers feel affectively the need to maintain good relations with clinicians with whom they come into contact day-to-day.

14.1(b) Internalisation of the policy agenda

Internalisation means to 'incorporate within oneself beliefs, attitudes and values' (Collins, 1999). As indicated in Chapters 2, 3 and 4, the underpinning agenda of health policy as it related to mental health was to encourage NHS personnel to incorporate within their schema principles of economic management and the management of risk.

Amongst a number of managers and clinicians recognition of resource constraints as part of the practice environment was notably internalised. The explanation for this appeared connected to an acceptance that resources had to be focused on those in

greatest need and that this was an 'efficient' and 'effective' use. This was combined with an internalisation of risk avoidance and risk management, which transferred itself to the management of resources through a belief that these needed 'stewarding'.

Lipsky (1980) argues that the client's identity is re-constituted as part of the process of managing professional anxiety. As argued in Chapter 5, Section 5.2(d), he does not appear to consider the degree to which internalisation of policy values play a part in this reconstitution. In this regard, however, the above suggests that a number of clinicians re-constituted the identity of the 'user' into the 'user with or without SMI' and the user 'at risk' because they accepted the legitimacy of such identities and then used these to judge appropriateness for treatment. Thus whilst management of practice pressures did play a part in this process, the internalisation of policy focus and values also influenced it.

The internalisation of a schema of risk seemed to have a difference of nuance between some managers and clinicians. A number of managers accepted its political significance hence they employed a risk heuristic in relation to policy issues with regard projection to external audiences such as the speedy reporting of 'risk' incidents or the emphasis on the 'safe' management of resources.

However, a number of clinicians did not engage with this 'political' construction of risk, though some recognised its presence. For them 'risk' was not associated singly with the assessment and prevention of disruptive behaviour on the part of users but rather with the development of a sense of insecurity and the use of a schema of risk evaluation to self and potential for censure. In other words these principles were incorporated by some into practice as a means of protecting themselves from criticism and blame. They extended beyond the task of focusing on the management of user behaviour to a reluctance to take on users who might be socially disruptive and distract from other aspects of one's caseload or lead the responsible individual into professional difficulties. This also helps to explain for example, the emphasis on the concern to be seen to be achieving targets and a focus on SMI, which extends beyond an identification

of that group as the only group legitimately entitled to call upon the CMHT as a resource.

14.1(c) Policy differences and policy tension

There did not appear to be any significant differences between Trust managers towards mental health policy in general. Though whether or not an individual manager had a clinical background did appear in some cases to influence their degree of comfort with policy and their process of interpretation of it. Many managers tended to emphasise their dislike of policy that interfered with the Trust's 'span of control' in relation to policy implementation or disrupted their relations with clinicians. This dislike may also be seen to arise out of a contradiction in a policy rhetoric that on the one hand insisted that managers be allowed to manage, whilst on the other emphasised Government action and prescription in the field of community mental health.

Policy tensions between managers tended to focus on each other's relative span of control. This covered tensions between the professional and operational managers over the management of clinicians, annoyance with the commissioners about their reluctance to keep the Trust informed in good time about the overall resource situation or concern over the potential power of GPs to dictate the service focus of the Trust.

Policy differences within the CMHTs also appeared to be minimal overall. The main point of difference as with managers related to 'span of control'. Firstly, with regard to clinical team leadership, which appeared to introduce a tension into the relationship between professions allied to medicine and the consultant psychiatrists. It was also one of the principal sources of grievance held by a number of clinicians against management. However, there was also dislike amongst some of what was seen as the Trust's decisions about closing services and the perception that the Trust was giving clinicians a 'mixed' message about meeting the needs of GP fundholders whilst concentrating on the management of SMI.

Overall, one might argue that there existed for both managers and clinicians a conflict of policy normative expectations (Lipsky, 1980; Merton and Barber, 1976). Management in its attempt to resolve its difficulties, created further ones for clinicians. Whilst these were significant causes of policy tension between clinicians and management the most significant was the demand by managers for information and the distrust and resentment this raised because of clinicians' sense of being monitored and their clinical freedom restricted. Such resentment appeared to be often translated into implementation manipulation with regard information systems and record keeping as a consequence.

The fact that a number of managers recognised information as a source of tension did not seem to result in a policy change towards its collection and the nature of the information asked for but rather an attempt to persuade clinicians that the supply of such information would be in their clinical interest. This attachment to the process of information collection was to some degree dictated to the Trust by external stakeholder, Government, DHA commissioners and GP fundholders. However, the emphasis on information process, for example regularity of information returns on clinicians' caseload contacts, may also be seen as a means of managing institutional anxiety, a seeking of reassurance that that which is prioritised in terms of implementation is provable (Karen, 1990).

A number of clinicians also appeared to judge the 'ritual' of information giving not in terms of their clinical interest but in terms of its personal value in securing them from criticism. They appeared to view the monthly return of caseload contact information as a necessity in order to manage their personal anxiety that they be seen to implement policy.

Overall therefore we see in this example of information giving a differentiation in anxiety between the two. For managers information receipt was part of the ritual for allaying a *corporate* anxiety. For clinicians, information giving was a ritual to allay *personal* anxiety.

14.1(d) 'Negotiating' implementation

A collusive relationship seemed to exist between managers, both DHA and Trust, and clinicians within the CMHT over the implementation of certain national policies – namely CPA and Supervised Discharge - in which it was informally agreed that the policy would only be implemented in part in the former and apparently only symbolically in the case of the latter. This collusive agreement seemed motivated by a shared perspective on the utility and implementability of such policy and relied on the lack of detailed central prescription on the implementation of the former and the use of clinical discretion in the application of the latter.

In the area of primary tension between managers and clinicians, information demands, there appeared to be a limited degree of tolerance with lack of clinician compliance in such areas as the maintenance of records and certain clinicians supplying information in written format rather than through the prescribed computerised channel. This toleration may have been prompted by a desire not to antagonise clinical staff in an area of policy, which was already a cause of friction, combined with a recognition that some information that was supplied was not accurate. The emphasis on contacts and case load numbers was the primary area of information concern for the Trust and it would appear as long as clinicians furnished the Trust with this information other areas were not as vigorously pursued. Of course this could change if the Government or commissioners changed priorities and chose to emphasise the achievement of different policy targets.

14.1(e) Situated and affective influence on perspectives and implementation

For a number of managers there were two situational and personal factors that appeared to affect their perspectives and implementation of policy. The first was their professional identity outside of their managerial capacity. The second was their affective response, particularly amongst those who had regular day-to-day contact with clinicians.

Amongst CMHTs, situation also influenced perspectives and responses to policy, for example, the situational sense of professional and managerial autonomy amongst some psychologists and social workers in relation to policy challenge. An important

situational influence, perhaps because of its interaction with individual affect, was the CMHT, which acted as a fulcrum in which a number of clinicians exchanged views and feelings about what they were expected to implement and received validation of their policy opinions. It would appear that such an equivalent environment was not available to managers, particularly middle managers, such as service managers of the CMHTs. Yet they were regularly exposed to a CMHT 'team' ethos, which, perhaps. served to intensify their feeling of policy isolation and being scapegoated by clinicians. This may also indicate the importance of managers in attempting to keep the CMHT 'onside' so that their affective isolation would be reduced.

A fear of consequence in relation to career and employment seemed to have influenced a number of clinicians' implementation of policy though this did not mean that policy was fully or 'truthfully' implemented. There appeared to operate in this regard a situational and affective calculation involving the policy importance - gauged either by the extent of information sought on implementation or personal instruction given - with the degree the individual was likely to be held personally to account for implementation and the likelihood of exposure should implementation either not take place or only partially take place. Priority was then given and a decision made about the degree of implementation once this had been assessed. Overall, an affective sense of fear in relation to criticism and censure was calculated through risk, which then focused clinicians' prioritisation of policy. This manner of decision-making would appear to be a form of 'bounded rationality' in which the dominant calculation is not optimisation of implementation but rather what is satisfactory.[173]

14.1(f) Explaining implementation in community mental health – comparing heuristics and schemata

As described and discussed in Chapter 11, Section 11.3 and Chapter 13, Section 13.5, a number of managers and clinicians appeared to interpret and implement policy with reference to particular heuristics and schemata. Whilst both managers and clinicians shared similar heuristic constructions, 'economic' and 'risk', to guide their decision-making, their overall schema differed as it related to their construction of 'self and risk'.

[173] Chapter 5, Section 5.2 g

Trust managers viewed 'risk' in a corporate sense, that is a threat to the well-being of the organisation and its relationships with a range of audiences, both external and internal. It was rare for managers to discuss 'risk' in personal terms; but in the few cases where they did, it was discussed in an abstract way and seen as a feature of the job they were in. Alternatively, some managers did display an affective perspective in relation to policy, which may have influenced their implementation. However, this affective reaction appeared to defer to the construct of the well-being of the organisation. Thus managers appeared rarely to construct their overall implementation heuristics in terms of 'risk to self'.

Clinicians differed from managers in that they tended to reference their schema and heuristics to 'risk to self' and 'audience'. For example, clinicians' 'economic' heuristics related to a desire for a 'bounded' rationalisation of demand on themselves and the CMHT. Thus their attitude to utility of information was related to its value to self and for their practice. The importance of meeting targets was related to demonstrating to management their policy compliance whilst the argument that SMI should be the CMHT priority was related to reducing the demands from other agencies on theirs and the CMHTs clinical time; at the same time acknowledging management and government policy priority.

Similarly, clinicians' construction of 'risk' was influenced by perceived personal consequence in being seen not to perform in areas of policy, for example the management of user behaviour or meeting caseload targets. Thus clinicians' implementation schema tended to operate in reference to their well-being and not that of the corporate body, which they saw as an audience whom they had to please.

14.1 (g) 'Sufficiency' of implementation

The degree to which policy was subject to informal agreement between managers and clinicians as to the nature of implementation, particularly when it involved policies which were either disliked or about which there was some qualified concern, marks one point of intersection between the heuristics and schema utilised by Trust management and the CMHTs with regard a calculation of implementation. For example, the CPA and

Supervised Discharge fall into this 'joint enactment arena'. Both managers and clinicians saw these polices as problematic either in terms of their utility, the clinical and resource demands they were likely to make or the level of tension they brought into the relationship between management and clinicians.

Nevertheless, the 'stakeholders' in these policies, in this case central Government and the DHA commissioners, required corporate evidence of implementation, which inevitably meant that Trust managers required clinicians' compliance. However, these policy stakeholders sent a message to Trust management about the vigour with which these policies were to be implemented. Thus with Supervised Discharge reliance on clinical discretion indicated that compliance required corporate systems to be set in place so that it was available as a clinical management option. In the case of CPA both central Government's refusal to prescribe detailed implementation guidelines and the DHA's requirement that they be informed about level (and not quality) of implementation annually enabled the Trust to make a decision not to implement the policy vigorously and comprehensively.

Clinicians also engaged with these policy signals through Trust management's requirements and monitoring of implementation. Thus whilst at a corporate level the Trust was committed to full implementation, clinicians were enabled to exercise discretion in relation to the degree to which they applied each policy at street level.

Both management and clinicians therefore appeared to utilise a calculation of their respective 'economic' constructions in relation to their 'risk' constructions with the policy requirement and the audience that needed to be satisfied with regard to implementation. The resultant assessment of personal or corporate utility appears to have influenced the degree of implementation that the Trust, CMHTs and clinicians in relation to demonstrating policy compliance.

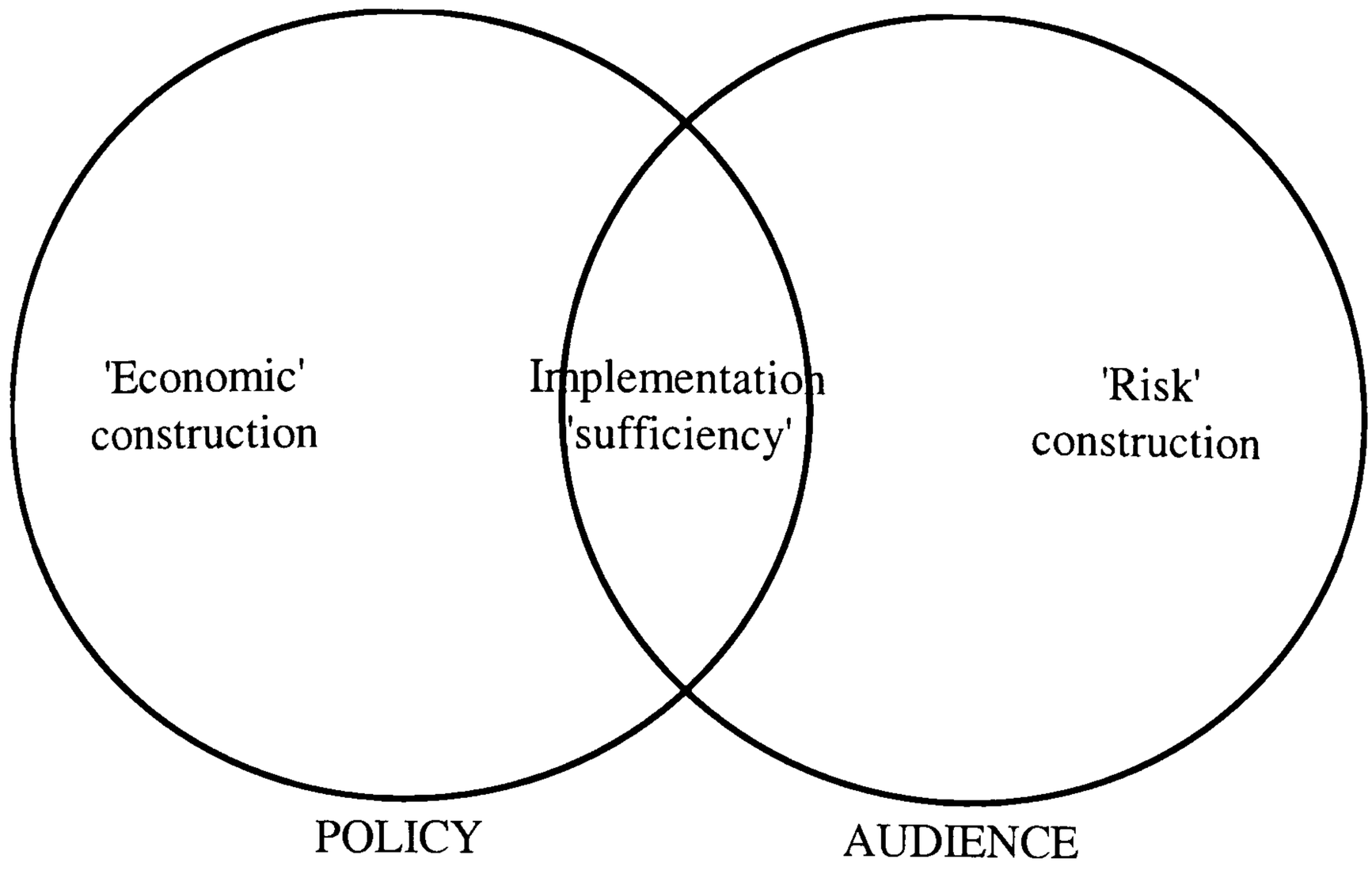

Figure 14.1

Calculating implementation 'sufficiency' in relation to policy and audience

One might describe the implementation response to this calculation as 'implementation sufficiency' (See figure 14.1). 'Sufficiency' encompasses within its meaning a demonstration of capability, doing enough to meet a purpose (adequacy) and being able to meet a need (Collins, 1999). Though synergistic to Hill's (1997) conception of 'bounded rationality' as it relates to implementing decisions[174] it may be argued to be superior to his concept of 'good enough' implementation in that it encompasses the need to *demonstrate* individual and corporate implementation *competence* and relates to a construction of implementation response on the part of actors that consists of a *continuum* from non-implementation to full implementation; points that 'good enough' does not convey. Thus we may see that in the policy response of CMHTs to Supervised Discharge and CPA a 'sufficiency of implementation' existed in which Supervised Discharge was applied to one user and CPA was applied to those identified as having a diagnosis of SMI since the 'audience' to which the CMHT had to relate indicated that this would be 'sufficient' to meet their requirements.

[174] See Chapter 5, Section 5.2g

14.1(h) Conclusion – the relationship of managers and clinicians to policy and the implementation environment

The opinion of a number writers is that mental health policy during the 1990s, for example CPA, either failed or was not effectively implemented (Appleby *et al.*, 1999; Burns and Priebe, 2002; Simpson *et al.*, 2003), though some take issue with this thesis (for example Leff, 2001; Hannigan and Cutcliffe, 2002). Both perspectives assume that mental health policy had as its agenda the successful care and treatment of people with mental illness in the community.

However, it could be argued that this study indicates that this view of the goal of mental health policy at this time is too narrow, and fails to recognise that mental health was part of a wider health policy agenda, which itself was influenced by a political and 'managerialist' philosophy based on neo-liberal conceptions of economy and responsibility. As discussed in earlier chapters[175] the general thrust of this philosophy as applied in the NHS was to persuade clinicians to accept an economic paradigm into their professional thinking and in mental health also to manage and be accountable for those users who engaged in risk behaviours to save the government political embarrassment in a society increasingly less tolerant of risk as a whole (Paterson and Stark, 2001).

In this context one might argue that much of mental health policy that was then formulated had as its target not users' care and treatment but managers' and clinicians' thinking and behaviour in operationalising care and treatment. Thus mental health policy during the 1990s with its discriminating focus on SMI, 'risk', and 'accountability', set against a backdrop of resource management, aimed to change the environment and structures of practice. In this sense it could be argued on the basis of the findings related to this case site that policy was a success in that it 'persuaded' both managers and clinicians to internalise 'economic' and 'risk' constructions that served to unite the interests of the *individual street level bureaucrat* with the *corporate street level bureaucracy* in the implementation of central focus of mental health policy. In this sense policy achieved an important goal in getting health service personnel to internalise

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[175] See Chapters 2, 3 and 4

a view of health care that was no longer individually based but related to a wider constituency in which discriminating between patients through conceptions of economic and risk constructions was not only inevitable but to some degree the right to do by associating it with CMHT and individual self-interest.

However, by doing so policy also appeared to create an implementation culture within the case site in which self-interest increasingly appeared to come to the fore in the assessment by some of policy and its implementation. An environment appeared to exist, in which clinicians resisted taking on 'difficult' users, such as individuals with personality disorder, and management and clinicians 'gamed' policy, in which establishing processes and being seen to implement became the focus of policy implementation. Thus an environment of policy manipulation was created in the case site in which a number of managers and clinicians focused on implementing policy that they felt served their corporate and individual interest. In this sense arguments that mental health policy failed because it was not implemented effectively may need to be reassessed (for example Simpson *et al.*, 2003). It was not so much that policy was not *effectively* implemented but rather that it was adapted to meet local clinical and corporate needs.

14.2 Credibility and transferability of analysis

Credibility and transferability of a qualitative policy study have three components that the reader needs to consider in their assessment. Spencer *et al.*, (2003) identify these as the degree to which its conclusions are supported by the evidence presented; are possessed of a coherent logic and are resonant with other knowledge, for example corroboration through triangulation of data sources and research evidence from elsewhere. This section deals with the latter, leaving to the reader alone the judgement as to whether the two former have been achieved.

Many of the issues identified in this study have also been identified by studies published since 1997. These include disaffection with principal elements of policy, such as CPA and Supervised Discharge (Simpson *et al.* 2003); the practice issues to arise in negotiating a contradictory policy environment (Secker *et al.*, 2000); a practice focus on

the management of risk (Raven and Rix, 1999); resource and policy pressures on mental health services and practitioners (Greengross *et al.* 2000); categorisation of users as a means of excluding them from CMHT care (Griffiths, 2002); tensions arising from joint working (Villeneau *et al.*, 2001); practice inconsistency in the definition of SMI (Ruggeri *et al.*, 2000); role relationships in CMHTs (Brown *et al.*, 2000); boundary tensions within and between CMHTs and other agencies (King, 2001; Gulliver *et al.*, 2002) and tension between CMHTs and local management structures and cultures (Brown *et al.*, 2000; Peck *et al.*, 2001) as a result of clinical demand and meeting policy. Indeed, a number of issues, for example the relationship of local implementation to national policy (House of Commons Select Committee on Public Administration, 2003); the relationship between primary care and tertiary mental health services (Rosen and Jenkins, 2003); the ability of mental health services to work co-operatively with social services (Glasby and Lester, 2004), differentials of policy implementation between agencies and organisations (Peck and Wigg, 2002) and the effect of resources on faithful implementation of mental health policy (Brooker *et al.*, 2003) continue to be issues of debate and interest.

Thus this study's findings at the descriptive level would appear therefore to possess both credibility and transferability with regards the published literature on mental health policy implementation in the UK for this period. However, at the interpretive level of the relationship between cognitive and behavioural processes of policy and implementation, credibility and transferability as it relates to the literature is harder to assess since this is not an aspect that is often addressed in the discussion of mental health policy and its operationalisation; particularly within the context of the theoretical literature on implementation. One must therefore view my interpretive conclusions from the stance of the degree of synergy with discursive and empirical studies of mental health policy operationalisation on the one hand and the relationship of my interpretative conclusions to the theoretical literature on implementation on the other.

14.2(a) Interpretive resonance with theoretical work

Sabatier (1999) argues that credible policy analysis to be located and related to more than one theoretical perspective. The central interpretive claim of this study is that there was a discernable interactive schematic construction of economic and risk heuristics within the case site that at times influenced the priority and degree to which policy was implemented; and that this schematic operated in relation to the nature of the policy and the audience to whom implementation was addressed. At a theoretical level a number of writers on implementation acknowledge that such schematics may operate, for example in the formulation and implementation of environmental or education policy (Bressers *et al.*, 2000; Spillane *et al.*, 2002). At the same time it is recognised that this is a poorly developed area of implementation theory (Spillane *et al.*, 2002).

Fisher's (1998) theoretical work on heuristics was a significant influence on interpretation in this study. The heuristics interpreted as operating within the case site do resonate with those he identifies. However, they also differ in that he identifies heuristics as operating discretely in relation to audience and implementation, whereas they are considered in this study as part of an interactive schema. Furthermore, he locates his heuristic scheme wholly within a resource construct of policy whereas the interpretation given here acknowledges a further level of complexity in relation to 'risk'.

The descriptive findings of the case study do resonate with aspects of Lipsky's (1980) work on street level bureaucracy, for example the value of peer support as it related to policy opinion, a focus on boundaries as a means of managing anxiety and risk and a dislike of that which interferes with professional discretion. However, at the interpretive level resonance is more complex. It can be argued that the schema suggested here resonates with Lipsky's (1980) central contention of the policy re-interpreting power of the street level bureaucrat. However, certain specifics of this interpretation depart from those he suggests. For example, the emphasis on 'economic' constructions in this interpretation do resonate with the central importance Lipsky (1980) ascribes to such constructs for the street level bureaucrat in their approach to implementation; but depart from his view that resource constraints are a source of external tension in relation to the

street level bureaucrat. The interpretation in this study is that at least for some they became an internalised construct of justification in their sense making of policy and decision making with regard implementation and interact with the clinician's assessment of risk to self.

This interaction then lends itself to a further departure from Lipsky's (1980) contention of the various ways the street level bureaucrat manages their relations with clients, since he sees their policy response as involving an engagement with clients. However, the introduction of the construction of risk in this case indicates that in some circumstances the street level bureaucrat's policy response may be to attempt to avoid responsibility and interaction with particular clients. Thus the suggestion in this study is that the question of practice tension is more complex than Lipsky's (1980) focus on resources allows for.

Overall, the interpretation of the case with regard extant theoretical literature does have credence in terms of its focus on heuristics and schema and limited confirmation in their operation. However, it may be argued this limited confirmation arises from issues that raise questions about the comprehensive applicability of identified theory in this particular case of mental health policy implementation.

14.2(b) Interpretive resonance with empirical work

Establishing interpretative resonance with empirical work is difficult for a number of reasons. Firstly, few studies of mental health policy attempt to encompass levels of implementation that is both managers and clinicians. Secondly, studies do not often combine constructions of 'risk' with 'economic' constructions. One is therefore left to consider studies that deal primarily with concepts discretely or deal with their inter-relationship implicitly. Fourthly, studies in mental health policy often do not address the specific impact 'audience' has on implementation beyond discussion of Government policy and the relationship of mental health policy to public perceptions. Finally, studies may not be concerned with the same issues with which this one was or may employ a different theoretical underpinning. Therefore the reader needs to bear these issues in

mind when resonance is inferred with the interpretive level found in other empirical work. Nevertheless it may be contended that resonance can be found in this study.

Thus for example, the general consensus on the nature of health care decision making in the NHS is that it is more subject to external examination and interference than it was previously (Light, 1998; McEvoy, 2000). Wells (1997) identified the creation of tiers of CPA priority as an indicator of the relationship between priorities based on resource limits and the need to manage risk. Crowe and Carlyle (2003) in a deconstruction of the concept of 'risk' as used in mental health policy and practice in western countries identified that it was motivated by societal rather than clinical concerns and had become a means of meeting the fiscal needs of organisations. Simpson *et al.*'s (2003) review of the literature on the implementation of the CPA concluded that it failed because of the interaction of underfunding and targets with a focus on the management of user behaviour and the resultant resistance and disaffection this produced amongst clinicians. These general views on mental health policy would seem to resonate with my conception of the inter- relationship of policy to audience and the connection of both to corporate 'economic' and 'risk' constructions influencing implementation.

The construction of 'audience' as it relates to 'risk' and 'sufficiency of implementation' at the street level may be seen to operate to in a number of studies. Stark *et al.* (2002) indicated that both managers and clinicians within CMHTs took account of the different organisational structures in determining their practice responses. King's (2001) study of practitioners from one CMHT identified the interaction of 'risk' and the policy priority of SMI in defining legitimacy of access to CMHT services in the minds of practitioners as a mechanism for protecting the CMHT from clinical pressure. Morrall's (1997a) study of CMHN practice in four CMHTs noted a range of strategies that nurses engaged in to manage their case loads in relation to different groups who made demands upon their clinical time. For example, they limited their contact with GPs as a means of avoiding clinical demand from this quarter, indicating the interaction of 'risk to self' with 'audience'. This did not mean however, they refused referrals from GPs once they received them; again indicating 'sufficiency of implementation' in their calculation.

Overall, therefore it would appear that the interpretation outlined above (See figure 14.1) does have a certain resonance with empirical work published elsewhere at least in terms of the importance these interpretive elements have in a consideration of mental health policy. The area of weakness is the corporate link between clinicians and management in implementation outcome. Thus in terms of confirming interpretation the literature would suggest credence rather than confirmation.

14.3 Methodological critique

Policy implementation research through case study inevitability has to reduce highly complex phenomena to more easily manageable constructs if processes are to be made intelligible to the 'outsider'. Thus a weakness of case study is 'simplification'. Some of the weaknesses of this study were indicated earlier[176]. This section deals with those areas not dealt with earlier.

14.3(b) Use of a non-emergent design for the collection and analysis of data

Overall, a non-emergent design was used to gather and analyse data for this case study. This may be criticised because it differs from the more usual approach to qualitative research advocated by such writers as Lincoln and Guba (1985), who emphasise the emergent approach in qualitative design in which data is analysed as it is collected and new avenues of enquiry are pursued as a result of an on-going analysis.

This 'purist' approach was not followed for three reasons. The development of the conceptual framework used to guide data collection precluded this.[177] Consequently there was a clear idea as to who needed to be studied in terms of sample and the general questions that needed to be addressed to meet the research aim. Maykut and Morehouse (1994) point out that although a non-emergent approach to qualitative research is less open and flexible compared to an emergent one, it can nevertheless yield valid and significant findings. Furthermore one adhere 'slavishly' to one approach in terms of the 'reality of research'. Thus there was a nuanced 'emergent' aspect to this study in that when interviewing managers a degree of reliance was placed on their recommendation

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[176] See Chapter 7, Section XX
[177] See Chapter 5, Section 5.3

of individuals they felt might be useful to contact, but this was not a significant aspect of the data collection process.

14.3(c) Analysis of textual and observational data

The subjectivity of case study is a recognised weakness of the approach since it involves the selection and arrangement of 'facts' and observations into configurations from which one then attempts to draw conclusions (Johnson *et al.*, 2004). Clearly a potential weakness of this case study overall was the subjectivity involved in having only one researcher to engage in textual and observational analysis (interview transcripts, documents and attendance of meetings and note taking). Arguably a better approach would have been to have subjected the material to separate analysis by another researcher and then engaged in a comparative of descriptive codes in order to develop and apply the final framework to the data (a form of inter-rater reliability).

In practice such an approach would have proved impractical with regard this particular study, in part because it was an unfunded. Thus access to the range of support, including a research assistant, available to a funded study that enables such dual coding of considerable amounts of data, gathered over extended time frame, was not possible.

As indicated in Chapter 7, Section 7.6, the issue of subjectivity was dealt with in a number of ways. I discussed my thoughts about the data with experts in a specific forum and subjecting the analysis and conclusions to the scrutiny of my supervisor.

However, two points need to be made in terms of subjectivity. The first relates to an earlier discussion of authorial voice as a means of alerting the reader to the fallibilistic nature of research.[178] My claim is not that this study and its conclusions are absolute truth but rather interpretations of events and conversations conducted with significant participants in one case site over issues, which it may be argued, have a wider import. The degree to which subjectivity affected conclusions will need to be gauged by the reader in terms of their credibility and transferability to other environments and in the context of the overall literature.

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[178] See Chapter 1, Section 1.4

14.4 Areas for further research

This case study had as its focus the relationship between policy and 'actors' in a community mental health service as a means of exploring questions of implementation. It examined services and practitioners at a time, arguably, of unprecedented controversy surrounding mental health policy, occupying the centre of the political stage in the UK. The degree to which mental health practitioners are subjected to socio-political constructs compared to other branches of medicine has been a subject of some discussion (Reich, 1991; Müller-Hill, 1991).[179] McFarland-Icke (1999) suggests an important question for investigation with regards health care professionals in times of policy controversy is an examination of the rationalisation process in which they engage in implementing policy with which they disagree. This study suggests the importance of internalisation of socio-political constructs and self-interest in this process.

There is a lack of consensus as to what are the significant variables in agency and actor compliance in relation to policy and thus the development of a comprehensive theory of policy implementation remains elusive in this regard (Bali, 2003; Sabatier, 1999). This case study suggests a number of areas where such development in the field of mental health might be undertaken. It dealt with policy at the intermediate level of management and the street level of clinicians prior to contact, in part as a consequence of limited resources, so as to trace commonalities and difference in the interpretive and implementation process. Griffiths (2003) has pointed to the rising interest in tracing policy relationships between macro-, meso-, and micro- levels. He suggests that such analysis might be more effective if 'researchers were to treat the distinction between these levels as phenomenon interactionally accomplished by organisational members"(p.160). A larger scale study might attempt to trace the interactive process and schema relationships from national formulation to direct 'felt' implementation by users as a means of developing a comprehensive view of the policy implementation process that is currently lacking in the mental health literature in the UK. Theory might be further developed in the area of mental health policy through research on the nature of heuristics and schema and specifically on the implementation impact of the need to satisfy the various 'audiences' to which policy is addressed.

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[179] See Chapter 1, Section 1.6

14.5 Conclusion

Griffiths (2003) states that, "in order to understand organisations we must understand people accomplishing organisation in a multitude of locally situated interactions"(p.158). The importance of interaction in policy sense making and re-interpretation in the implementation process has been regularly attested to in the literature (Hunter, 1979; Lipsky, 1980; Scheid, 2000). This case study further adds to this literature. Its analysis of the nature, relationship and importance of individual and corporate heuristics and schema adds a further dimension to the study and discussion of street level bureaucracy. Indeed, it is one of the first studies to examine the impact and inter-relationship of 'economic' and 'risk' policy constructs on the cognisance and practice of staff in mental health care in the UK. The conceptual suggestion of 'implementation sufficiency' further contributes to the discussion on the nature of implementation behaviour by acknowledging both a continuum of implementing activity in which there is a recognition that implementers' actions can aim to comply with policy as well as change it.

Burawoy (1991) states that the significance of a case relates to what it can tell us about the social world in which it is embedded. This case is one of only a few studies that examine mental health policy implementation as a whole rather than one aspect of policy, attempting to do this by focusing on the various implementing actors at the meso- and micro- level rather than one discrete level of implementation. Its central finding is that implementing actors respond to policy in ways that they believe will meet the agenda of those monitoring the policy implementation as a means of protecting themselves. It is in this sense an argument for a mental health policy analysis that addressed itself to policy in a wider political context and considers in its conception of mental health service delivery the view that the target of much policy is not mental health service users but mental health professionals.

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Appendix A

Literature search strategy

Searching the Literature

Because of the length of this project from initiation to completion the literature search was an on-going process, rather than confined to one discrete stage as often portrayed in work on the subject (Hart, 2001). The literature regularly had to be checked for changes in the general discourse around mental health policy, the history of UK mental health policy and CMHTs during the 1990s and changes in theory development in relation to policy implementation and case study. The main literature sources consulted were journal articles, books, official reports from government agencies, reports from campaigning agencies, reports from policy analysis institutes and occasional newspaper articles from the quality press.

Decisions on inclusion/ exclusion were relevance to research subject - that is mental *policy implementation* in the UK during the 1990s; author, that is an author known to write regularly on the subject and relevance to the notion of 'case' as a research concept. If articles/ books/ reports met one of these criteria they were immediately included. Three primary means of gathering literature were then employed.

Computerised databases

The computerised databases consulted ranged across medical, nursing and social science. The primary ones consulted were PubMed, Cumulative Index on Nursing and Allied Health Literature (CINAHL) and the Social Science Citation Index (BIDS) and the data bases located on the Department of Health and House of Commons websites. From 2001 Web of Science was also regularly utilised.

Boolean terms 'and' and 'or' were used to refine searches in relation to the use of key words. The key words regularly employed singly and in combination were:

- Case study
- Care Programme Approach/ CPA
- Community
- Community Mental Health Team/ CMHT

- Compliance
- Economics
- Fundholding
- Government
- Implementation
- Legislation
- Mental health
- Mental illness
- Method
- National Health Service/ NHS
- Policy
- Politics
- Research
- Severe mental illness/ SMI
- Trust
- UK

To further narrow the search in terms of relevance to the project abstracts were read when available. Otherwise the title of the article combined with journal of publication were utilised to decide upon the likely utility of the citation with reference to the inclusion/ exclusion criteria outlined above.

In addition to this approach to computerised databases I also used the alerting services from 2000 offered by the British Medical Journal and a number of journal publishers, for example INGENTA.

Following up cited sources

Published articles were then searched for further key references (these were defined in relation to number of times they were cited in articles or in relation to author, for example 'Onyett' or 'Peck' and then referred to the inclusion/ exclusion criteria outlined above. This strategy mainly proved important in locating key books. The references in these books were also reviewed in a similar manner.

Following up recommended literature

In addition to using the computerised and printed matter to identify key literature I also followed up recommendations from colleagues and experts. This means was for

example significant in alerting me to the work of Michael Lipsky in the early stages of this project.

Organising the literature

I did not use a referencing computerised package such as End Note to maintain and organise my literature. Rather I used a file system organised under MS Word. This was organised into three files – references used in the research report (this was maintained as the report was written); bibliographical citations (this incorporated all the literature I read) and references used for analysis, (for example government reports and guidelines used as part of the analysis in Chapters 2, 3, 8 and 9). The first and last of these were combined in the reference section to this report. The latter is also separately reported in Appendix D.

Reviewing the literature

In terms of deciding which literature to cite, particularly in the Parts I and II of this report, firstly I was influenced by the need to present the development of the policy issues that were debated during the 1990s. This meant a chapter focus on the most influential authors, articles, reports and books published at the time data collection took place. Thus empirical considerations, for example a consideration of issues of reliability and validity in relation to cited research reports, were a secondary to the primary purpose of the review. Literature cited that was published after the time of data collection was cited where I felt it threw light or a new perspective on the issues I had examined.

Appendix B

Significant policy documents and initiatives 1959-1997

Significant policy documents and initiatives1959-1997

1959 'The Mental Health Act'

1961 'The water tower' speech, Minister for health Enoch Powell

1962 'Hospital Plan for England and Wales' Ministry for Health

1970 'The Local Authority Social Services Act'

1972 Departmental circular (35/72) 'Planning guidelines for residential facilities for the mentally ill'

1975 White Paper 'Better Services for the Mentally Ill'

1976 'Joint Care Planning Health and Local Authorities' DHSS

1977 'Health Services Development: the role of psychiatrists in the health services' HC(77)14

1977 'Mentally disordered offenders. Care and treatment' HN(77) 107 & HN(77)97

1978 White Paper 'Review of the Mental Health Act'

1981 'Development of CPN Services' CNO(81)10

1981 'Care in Action: A Handbook of Policies and Priorities for the Health and Personal Social Services in England' DHSS

1983 'The Mental Health Act'

1983 'Health Service Development: Care in the Community and Joint Finance' DHSS

1985 'Community Care with special reference to adult mentally ill and Mentally Handicapped People' Social Services Ctte

1986 'Making a reality of community care' Audit Commission

1987 'Mentally disordered offenders. Prisons, Treatment. Patient Care' EL(87)P/18

1988 'Community Care Agenda for Action' Griffiths

1989 'Discharge of patients from hospital' (covered all hospital discharges) HC(89)5

1989 White Paper Caring for People: Community Care in the Next Decade and Beyond

1990 'NHS and Community Care Act'

1991 'Guidelines on the Care Programme Approach' HC(90)23 LASSL(90)11

1992 Health of the Nation Strategy for Health in England

1992 'Department of Health/ Home Office review of services for mentally disordered offenders and others requiring similar services' CM2088

1993 Ritchie inquiry established

1993 Mental health task force established

1993 Ten Point Plan

1993 Review of legal powers

1993 Full implementation of NHS and Community Care Act

1994 Ritchie report

1994 Supervision Registers HSG(94)27

1994 Confidential inquiry into homicides and suicides by mentally ill people preliminary report

1994 'Better off in the community' The Care of people who are seriously mentally ill' Health Select Ctte

1994 'Finding a Place' Audit Commission

1994 Mental Health Nursing review

1995 The Mental Health Act (Patients in the Community)

1996 Mental Health Patients Charter

Appendix C

Consent Form

LETTER SENT TO INDIVIDUAL INTERVIEWEES

Name and address

28.11.97

Dear X

re: Project on an investigation of factors affecting community mental health teams' achievement of commisssioned goals by John Wells, Lecturer King's College London

I am engaged in the above study with the co-operation of the Borough Focused Commissioning Directorate and XXX NHS Trust. I am writing to you to enquire whether you would be prepared to participate in an interview as part of this process.

The purpose of the interview will be to gain your perspective on issues that I have identified from the research so far. The interview will be recorded and transcribed for the purpose of analysis. No one other than myself will, transcribe or read the material you furnish me with, though anonymous quotes from the interview along with those from other participants may be utilized in the final report. Your identity will not be given in the final report on the project in relation to either your participation or any quotes I may use.

Tapes and transcriptions will be held in a secure place and then destroyed once the project is complete. If you think that you would be able to participate, could you sign the enclosed consent form and indicate the most convenient times and dates you could see me. Return these to me in the pre-paid envelope. I will then write to you shortly to confirm the venue, time and date.

Should you have any queries at any time you may contact me either at work on 0171 872 3024/ext 3231 or alternatively you may ring me at home on 0181 689 9969. Thank you for your help and I look forward to hearing from you.

Yours Sincerely

John SG Wells
Lecturer

LETTER SENT TO GROUP INTERVIEWEES

Name and address

Date

Dear XX

re: Project on an investigation of factors affecting community mental health teams' achievement of commisssioned goals by John Wells, Lecturer King's College London

Over the past year I have been engaged in the above study with the co-operation of the Borough Focused Commissioning Directorate and Pathfinder NHS Trust. I am in the final stage of data collection and am writing to you to enquire whether you would be prepared to participate in a small group interview as part of this process.

The group interview will take place in January 1998. It will be conducted by myself and will take approximately one hour. The group will number four in total with the other members of the group occupying a similar type of role to that of yourself. The purpose of the interview will be to gain a perspective on issues that I have identified from the research so far through group discussion. The interview will be recorded and transcribed for the purpose of analysis. These tapes and transcriptions will be held in a secure place and then destroyed once the project is complete. No participant will be identified in the final report on the project.

The interview will take place at XX.. A small honorium of £50 will be paid to you for your participation. Refreshments will also be provided. If you think that you would be able to participate, could you sign the enclosed consent form and indicate the most convenient times and dates you could attend on the attached schedule. Return these to me in the pre-paid envelope. I will then write to you shortly to confirm the venue, time and list of your fellow group members.

Should you have any queries you may contact me either at work on 0171 872 3024/ext 3231 or alternatively you may ring me at home on 0181 689 9969. Thank you for your help and I look forward to hearing from you.

Yours Sincerely

John SG Wells
Lecturer

CONSENT FORM

Please complete the form below

Re: **An investigation of factors affecting community mental health teams achievement of commissioned goals**

I have read the accompanying letter regarding the above project

and I agree to be interviewed for the above study ☐ (Please place a tick in the box)

I do not wish to be interviewed for the above study ☐ (Please place a cross in the box)

I am available for interview on (Please give two dates and times)

1. ……..
2. ……..

My contact telephone number to arrange for the above is .....

Signed .....

Please print name .....

Please return in the accompanying SAE

Thank you for your help

John Wells

EXAMPLE OF SCHEDULE SHEET SENT TO GROUP PARTICIPANTS

Please indicate the times you can attend under the dates by placing a tick. Return this with your consent form in the envelope provided. Please try and give as many options as possible

Date/Time	07.01.98	09.01.98	14.01.98	16.01.98	20.01.98
10.30-11.30					
12.30-13.30					

Appendix D

List Of Government/ DHA/Trust Documents Examined In The Study

CONTEXTUAL DOCUMENTS

LEGISLATION

Department of Health (1990) *NHS and Community Care Act* London HMSO

REPORTS

Audit Commission (1986) *Making a Reality of Community Care* London HMSO

Audit Commission (1994) *Finding a Place A Review of Mental Health Services for Adults* London HMSO

Blom-Cooper, L.; Hally, H.; Murphy, E. (1995) *The Falling Shadow One Patient's Mental Health Care 1978-1993* London Gerald Duckworth & Co. Ltd

Cocherane, D; Conroy, M; Lewis, R (1994) *A Profile of London's Mental Health Services- London Overview A Report for the Mental Health Task Force London Project* London Conrane Consulting

Department of Health (1999) *Still Building Bridges The Report of a National Inspection of Arrangements for the Inspection of Care Programme Approach with Care Management* London HMSO

House of Commons Select Committee on Health (1996) *Allocation of Resources to Health Authorities Vol.1* London HMSO

House of Commons Select Committee on Health (2000) *Provision of NHS Mental Health Services* 4th Report Vol.1 London The Stationary Office

House of Commons Select Committee on Public Administration (2003) *On Target? Government By Measurement Vol.1* London The Stationary Office Ltd.

Johnson, S; Ramsay, R; Thornicroft, G; Brooks, L; Lelliott, P; Peck, E; Smith, H; Chisholm, D; Audini, B; Knapp, M; Goldberg, D (eds.) *London's Mental Health The report to the King's Fund London Commission* London King's Fund Publishing

National Association of Health Authorities and Trusts (1994) NAHAT *Briefing Developing NHS Purchasing and GP Fundholding: Towards a Primary Care-led NHS No.75* Leeds NAHAT

NHS Executive (1996) *Mental Health Services in London Briefing Paper No 1* Leeds Department of Health

Ritchie, J.; Dick, D.; Lingham, R (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis* London North East and South Thames Regional Health Authority

Roy, D.; Lelliott, P; Guite, H. (1996) *Inner-City Mental Health – A report to the Council of the NHS Trust Federation* London NHS Trust Federation

Royal College of General Practitioners (1997) *Developing Partnerships in Mental Health Summary Paper* 97/3

Royal College of Physicians (1995) *Setting priorities in the NHS A framework for decision-making* London Royal College of Physicians of London

Social Services Inspectorate (1995) *Social Services Departments and the Care Programme Approach: An Inspection* London HMSO

Social Services Select Committee (1985) *Community Care with special reference to Adult Mentally Ill and Mentally Handicapped People* London HMSO

Spokes, J.; Pare, M.; Royle, G. (1988) *The Report of the Committee of Inquiry into the Care of and Aftercare of Miss Sharon Campbell* London HMSO

Tomlinson, B. (1992) *Report of the Inquiry into London's Health Service, Medical Education and Research* London HMSO

POLICY AND GUIDANCE PAPERS

Department of Health (1990) *Community care in the next decade and beyond* London HMSO

Department of Health (1990) *Joint Health/Social Services Circular Health and Social Services Development 'Caring for People' The Care Programme Approach for the People with a Mental Illness Referred to the Specialist Psychiatric Services* HC(90)23/LASSL (90)11, London HMSO

Department of Health (1990) *The Care Programme Approach for People with Mental Illness Referred to the Specialist Psychiatric Services* HC(90)23/LASSL(90)11 London HMSO

Department of Health (1991) *Joint Approaches to Community Care Planning* London HMSO

Department of Health (1993) *Health of the Nation: Mental Illness Key Area Handbook* London HMSO

Department of Health (1993) *Secretary of State: Ten-point plan. 1193/908* Department of Health London

Department of Health (1994) *Health of the Nation: Mental Illness Key Area Handbook* London HMSO

Department of Health (1994) *Introduction of Supervision Registers for Mentally Ill People (HSG(94)5)* Department of Health London

Department of Health (1994) *NHS Executive Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community (HSG(94)27/LASSL(94)4)* HMSO London

Department of Health (1994) *Working in Partnership: A Collaborative Approach to Care* London HMSO

Department of Health (1995) *Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people* London HMSO

Department of Health (1996) *The Spectrum of Care: local services for people with mental health problems* London HMSO

Department of Health (1997) *Developing Partnerships in Mental Health* London HMSO

Department of Health (1997) *The New NHS* (White Paper). HMSO, London

Department of Health (1998) *Modernising Mental Health Services: Safe, Sound and Supportive* London HMSO

Department of Health (1998) The Third Way for Mental Health Press Release

Department of Health (2000) *Mental Health National Service Frameworks* London HMSO

Department of Health (2001) *The Mental Health Policy Implementation Guide* London HMSO

Department of Health and Department of the Environment, (1995) *Building Partnerships for Success Community Care Development Programmes* London Dept of Health

NHS Executive (1994) *Developing NHS purchasing and GP fundholding* EL(94) 79

NHS Executive (1994) *Developing NHS Purchasing and GP Fundholding Towrds a Primary Care-led NHS* London HMSO

NHS Executive (1994) *Guidance on discharge of mentally disordered people and their continuing care in the community* HSG(94)27 London HMSO

NHS Executive (1994) *Introduction of supervision registers for mentally ill people from 1st April 1994* HSG (94) 5 London HMSO

NHS Executive (1995) *Developing NHS purchasing and GP fundholding HSG(95)4* Leeds NHS Executive

NHS Executive (1996) *Guidance on Supervised Discharge (After-Care under Supervision) and Related Provisions* HSG (96) I 1

NHS Executive (1996) *Priorities and Planning Guidance for the NHS 1996/1997* Leeds Department of Health

NHS Management Executive (1992) *Guidance on the Extension of the Hospital and Community Health Services Element of the GP Fundholding Scheme from 1st April 1993* London Healthcare Directorate, Service Development, London

NHS Management Executive (1995) *Towards a Primary Care-led NHS* London HMSO

NHS Management Executive (1995a) *GP fundholding: list of goods and services HSG (95) 19* Heywood Health Publications Unit

NHS Training Executive (1995) *Developing the Care Programme Approach: Building on Strengths* Bristol Department of Health

Secretary of State for Health (1994) Letter for the President of the Royal College of Psychiatrists *Psychiatric Bulletin* 18:387-388

DOCUMENTS SUPPLIED BY THE DHA COMMISSION

CMHT enhancement strategy (produced by Trust)

Joint Strategy Plan for Meeting the Needs of Mentally Ill People 1993

LA1 Community care plan 1996

LA2 Community care plan 1996

LA2 report entitled 'Mental Health Strategy: organisation and delivery of social work'

Minutes of commissioning steering group, 1996

DOCUMENTS SUPPLIED BY THE TRUST

Attitude and image survey report

Chief executive report to board for year 1995/1996

Clinical audit report 1995

Cocherane Report

Contract with DHA 1996/1997

Core quality standards 1995/1996/1996/1997 and appendices

Corporate business plan 1996/1997

Draft business plan 1996/1997

Guidance on producing Trust information leaflets

Long-term case register report 1996

Marketing report 1995/1996

Memo – communications between management and medical staff

Memo from health care evaluation unit 1996

Mental Health Act Commission report 1996

Mental Health Task Force follow-up report

Minutes of meetings with commissioners 1996

Monthly financial reports 1996

Purchasing intentions of GP fundholders 1997/1998

Quarterly Activity reports 1995/1996

Report on strategy for LA1 and LA2

Trust briefing paper on mental health services in London

Appendix E

Document Record Sheet

DOCUMENT ANALYSIS SHEET

1.Title of Document **Date *April 1996***

Policy guidance on the assessment and treatment of patients temporarily located outside of the geographical boundaries of [LA 1 and LA2]

2.Authorship

Deputy Chief Executive (DCEO)

3.How was the document distributed?

Circulated to the service managers. Appears to have been then communicated through these to the CMHTs.

4.Stated purpose of the document

To clarify responsibility for patients temporarily located outside the borders of LA1 and LA2 with regard whether a CMHT should continue to provide care. This was prompted following a patient incurring a serious injury a year before which raised a need for clarity of policy.

5.What is recorded in the document (Give examples)

Guide to CMHT Action

Teams must consider level of urgency and their knowledge of the patient

Managers will be required to provide support to teams where there are issues of disagreement with local services. Managers will also be arbiters where there is disagreement within teams over response.

5.How is the document written (e.g. formal, technical jargon, etc)

There is a covering letter explaining the general purpose followed by an accompanying document detailing process guidelines

6.Is there information taken granted?

There appears to be an assumption that readers will be aware of the general policy on this issue, ECRs, etc.. There is a detailed prescription of the process to be followed.

7.What is omitted in the document?

There appears to be nothing omitted form the guidelines except explication of policy

8.What do readers need to know in order to make sense of it?

Knowledge of legislation governing service responsibilities, names of relevant managerial authorities who must be consulted.

Does the document relate to theory?

Document relates to work on need to manage and reduce risk. It also relates to the dependency of managers on the support of SLBs and the degree to which managers engage in the control of discretion.

APPENDIX F

Interview guide

Interview topic guide

1. Awareness of policy

- Ask interviewee to identify what they think are significant policies and say why

2. Policy influence on work – Discuss with interview the following:

- Ask interviewee to describe their role
- What issues currently affecting your work? What and how do you prioritise?
- What issues cause you most concern in your work? Identify how they deal with policy issues
- How important do you think the demands for information are in relation to practice?
- How does your relationship with GP fundholders affect work?
- How do local policy requirements affect you?

3. Causes of personal anxiety

- What issues give you cause for concern? Discuss how these are managed.

4. Relationships between CMHT and operational managers

- Discuss the relationship between the CMHT and managers and how would the interviewee describe this relationship and its influence on work as it affects policy?

5. Communication and monitoring mechanisms

- What mechanisms exist for communicating your views
- In what ways does demands for information affect your practice and relations?
- How are you made aware of what the trust expects of you
- How aware are you of the commissioned priorities for your team?
- How important is audit to practice?

6. CMHT

- Discuss role relationship between the individual and team
- Discuss the internal governance of the CMHT
- What issues cause tension between team members?

Appendix G

Transcript extract of discussion with invited experts on developing thoughts on the data

J. W. A very strong theme that came out from talking to clinicians is how alienated from the policy process at trust level they feel. They don't feel they have an input into it but they are just told and that this can add to the stress. And I wonder if this could contribute to their Non- co-operation . One of the striking factors was of the two CMHTs that I was with, one didn't actually fill in any CPA documentation very much and the other had only managed to achieve 60% compliance. And yet we are told that C P A is the thing they have all got to fill in; yet clearly they are not co-operating because they feel it is an imposed thing and they all complain about it. Yet they can see the value of CPA which is the odd thing.

J. S. Some of them can but some of them can't. I was reading recently a piece by psychiatrists again saying the argument against it is that it is of no proven effectiveness in securing better outcomes for patients. So they are raising issues but there is no evidence that it will do any good. Whereas we know that cognitive behavioural therapy does do good because it has been well evaluated and yet it is very ill developed in many areas.

S. O. You have to be very suspicious of that rhetoric though because family therapy we know works but they don't do that. I think it is all that CP A forms are emblematic of the unwelcome presence of operational managers.

J. W. Clinicians say we have always done this any way.

J. S. Yes but I have thought about that in a lot of different contexts over years, because people always said that is what we are doing already, you know, and either think that is because of the way that we make sense of the World is that we have to assimilate new information into our own existing frameworks, I am a constructivist so I would think that, and that is the process you sort of mesh it in with what you know already and suddenly it is not this strange thing there it's oh! we have been doing that already.

I. R. My views are obviously influenced by my work with Lambeth health care but I would question whether the apparent intransigence or the lack of willingness to

implement something to do with CPA is necessarily attributable to the fact that it is perceived as a top down piece of legislation. Wherever you are it can potentially be seen and indeed it is a form of top down legislation but the way in which - people are expected to implement it and the assistance they are given in implementing it is a crucial factor here. If you look at Lambeth and their rates of 98, 99% they employed a nurse as a CPA co-ordinator, who went round his fellow colleagues and supported them in adapting it as a piece of legislation. Now that becomes an implementation issue rather than a top down bottom up struggle. So I think you can cut the cake lots of different ways and in my experience Lambeth is very different from that you have described.

J. W. yes I think it is a good point, it is not just about feeling things are important but how much space is given to clinicians to be creative, who has actually asked them to implement it and what role do they occupy.

All Agree

J.W. Just to finish on this section I was interested in the clinical autonomy, strength or weakness bit. Because in some ways it strikes me that if anything clinical, is actually being reinforced. I will give you a couple of ways in which I see it that way. First of all, the emphasis on a Primary care led NHS and the GP, who is now not only a provider of a service but a big Commissioner of services; secondly, the CM HT itself you could say was a reinforcement of clinical power because you are now encouraging clinicians to get together and act collectively whereas in the past they tended to act as individuals within their own discipline.

I.R. Potentially.

S.O. A big assumption though, because a kind of gestalt means the team is greater than the sum of its parts.

I. R. It can go the other way.

J. S. Yes.

S. O. In fact research suggests that it does, that the output of a team is less than the output of its most effective member in a kind of work group context.

J. S. When I was thinking of the word clinicians I thought of psychiatrists, not GPs, and I think in many respects there is not a lot of understanding across those two professional boundaries. So in fact GPs may be being handed more power but it doesn't have much bearing on what I know of psychiatry, it may in fact make psychiatrists feel even worse. I mean they do seem to come across as a group who feel like threatened and an endangered species at the moment in the literature.

Appendix H

Framework Charts

Framework 1 (2 1)Trust and Operational management interface	Framework 2 (2 2)Policy Cognisance
(2 1 1)Trust management distance (2 1 1 1) medics dominating management (2 1 1 2) managerial distance (2 1 1 3) different agendas **(2 1 2)Operational 'capacity'** **(2 1 2 1) Agent of policy** (2 1 2 1 1) opm is a conduit (2 1 2 1 2) enforcement of targets **(2 1 2 2) Non-empathic capacity** (2 1 2 2 1) good relations (2 1 2 2 2) 'them and us' (2 1 2 2 3) team resourcing (2 1 2 2 4) practice autonomy **(2 1 2 3) Communication and information** (2 1 2 3 1) communication avenues (2 1 2 3 1 1) professional discipline meetings (2 1 2 3 1 2) internal media (2 1 2 3 1 3) CMHT business meeting (2 1 2 3 2) resentment of informatics (2 1 2 3 2 1) information filtering (2 1 2 3 2 2) burdensome information giving (2 1 2 3 2 3) non-holistic information returns (2 1 2 3 2 4) defensive recording (2 1 2 3 2 5) negative scrutiny (2 1 2 3 2 5 1)crudity of measurement (2 1 2 3 2 5 2) caseload list gaps (2 1 2 3 2 5 3) keeping up-to-date paperwork (2 1 2 3 2 5 4) suspicion of monitoring (2 1 2 3 2 6)top down communication **(2 1 3) Financially led service restrictions** (2 1 3 1) closure, service use and referral restrictions impact on users (2 1 3 2) lack of physical resources	**(2 2 1) Policy legitimacy** (2 2 1 1) protects remit (2 2 1 2)level of interface distance (2 2 1 3) sympathetic to practice **(2 2 2) Policies mentioned** (2 2 2 1) focus on SMI (2 2 2 2) statutory policy (2 2 2 3) joint working (2 2 2 4) resource cuts (2 2 2 5) long term case register (2 2 2 6) consultant as team leader (2 2 2 7) meeting purchasers' needs **(2 2 3) Expressed opinions** (2 2 3 1) politicisation of mental health (2 2 3 1 1) allaying public fear (2 2 3 1 1 1) blame culture (2 2 3 1 1 2) prevent disasters (2 2 3 2) rationing resources (2 2 3 3) market philosophy (2 2 3 3 1) undervalued (2 2 3 4) lacks specificity (2 2 3 5) clarifies relationships (2 2 3 6) protects managers (2 2 3 7) policy is imposed (2 2 3 8) too much power (2 2 3 9) not helpful (2 2 3 10) helpful (2 2 3 11) management right to manage (2 2 3 12) nothing we can do about this policy

Framework 3 (2 3 1) Implementation dissonance	Framework 4 (2 3 2)Implementation displacement
(2 3 1 1) feeling negative about policy atmospherics **(2 3 1 2) marginal deferral** **(2 3 1 3) clinical discretion** (2 3 1 3 1) management collusion **(2 3 1 4) implementation sabotage** **(2 3 1 5) overt challenge**	**(2 3 2 1) permissiveness not to provide a service** **(2 3 2 2) dilution** **(2 3 2 3) brokerage** **(2 3 2 4) manipulation**

Framework 5

(2 3 3) Implementation cognitions

(2 3 3 1) Economic Man

(2 3 3 1 1) evidence based utility
(2 3 3 1 1 1) efficiency as effectiveness
(2 3 3 1 1 2) provision of process evidence
(2 3 3 1 1 3) proving professional utility through target achievement
(2 3 3 1 2) need to steward resources in clinical practice
(2 3 3 1 2 1) demand management
(2 3 3 1 2 2) cost consciousness
(2 3 3 1 2 3) priorities

(2 3 3 2) Risk cognisance

(2 3 3 2 1) community risk
(2 3 3 2 1 1) forensic danger
(2 3 3 2 1 2) responsible for community safety
(2 3 3 2 1 3) risk assessment
(2 3 3 2 1 4) deservingness
(2 3 3 2 2) managing risk to self
(2 3 3 2 2 1) adequacy
(2 3 3 2 2 1 1) contingent risk planning
(2 3 3 2 2 1 1 1) judging what one can leave
(2 3 3 2 2 1 2) personal responsiveness
(2 3 3 2 2 1 3) demonstrative compliance
(2 3 3 2 2 1 3 1) manipulating information returns
(2 3 3 2 4) personal performance comparatives
(2 3 3 2 4 1) professional standards
(2 3 3 2 4 2) comparative performance with colleagues
(2 3 3 2 5) rigour of emphasis
(2 3 3 2 5 1)direct instruction
(2 3 3 2 5 2) risk contingency
(2 3 3 2 5 2 3) being disciplined
(2 3 3 2 5 2 3 4)job security

(2 3 3 3) Affective response

(2 3 3 3 1) thankless work
(2 3 3 3 2) the 'fallguy'
(2 3 3 3 3) compromised
(2 3 3 3 4) professionally devalued
(2 3 3 3 5) dislike of GP power
(2 3 3 3 6) feeling controlled by immediate workload
(2 3 3 3 7) fear of move away from hospital to community
(2 3 3 3 8) feeling insecure about career

Framework 6

(3 1)"Living inside the team"

(3 1 1) Affiliation and role

(3 1 1 1) core members
(3 1 1 1 1) discipline
(3 1 1 1 1 1) nurses
(3 1 1 1 1 2) doctors and nurses
(3 1 1 1 1 3) medical, nursing, social workers
(3 1 1 1 1 4) medical, nursing and OT
(3 1 1 1 1 5) consultant, nurses, social workers, psychologist and OT
(3 1 1 1 2) no external allegiances
(3 1 1 1 3) personal attitudes
(3 1 1 1 4) peripheral members
(3 1 1 1 4 1) social workers
(3 1 1 1 4 2) psychologists
(3 1 1 1 4 3) OT
(3 1 1 1 4 4) psychosocial orientated practitioners
(3 1 1 1 4 5) those who opt out

(3 1 1 2) Shared Constructions

(3 1 1 2 1) regulatory
(3 1 1 2 1 1) pre-emptive assessment
(3 1 1 2 1 2) statutory consciousness
(3 1 1 2 1 3) maintenance of SMI
(3 1 1 2 1 4) being defined by keyworking responsibilities

(3 1 1 3)Distinct constructions

(3 1 1 3 1) medical
(3 1 1 3 1 1) CMHT leadership
(3 1 1 3 1 2) providing medical continuity
(3 1 1 3 1 3) exclusively managing dangerous patients
(3 1 1 3 1 4) provision of clinical cover
(3 1 1 3 2) psychologist
(3 1 1 3 2 1) third level skills
(3 1 1 3 2 2) work independently
(3 1 1 3 3) social worker
(3 1 1 3 3 1) children at risk
(3 1 1 3 3 2) assessing value for money
(3 1 1 3 4) CMHN
(3 1 1 3 4 1)'borderless genericism'
(3 1 1 3 5)OT
(3 1 1 3 5 1) define role by what we are not

(3 1 1 4) Professional identification points

(3 1 1 4 1) external identifications
(3 1 1 4 2) CMHT identification
(3 1 1 4 3) contingent identities
(3 1 1 4 4) reporting relationships
(3 1 1 4 4 1) professional management
(3 1 1 4 4 2) general management

(3 1 1 4 4 3) clinical team leader
(3 1 1 4 4 5) social work line management

(3 1 2) Workload and distribution

(3 1 2 1) size and nature caseload
(3 1 2 1 1) nature of case load work
(3 1 2 1 1 1) Schizophrenia
(3 1 2 1 1 2) Depression
(3 1 2 1 1 3) CBT problems
(3 1 2 1 1 4) personality disorder
(3 1 2 1 1 5) life problems
(3 1 2 1 1 6) mild anxiety
(3 1 2 1 1 7) substance abuse
(3 1 2 1 2) size of case load
(3 1 2 1 3) assessment results
(3 1 2 2) allocative routines
(3 1 2 2 1) consensual volunteerism
(3 1 2 2 1 1) self-selection
(3 1 2 2 1 2) allocated by consultant
(3 1 2 2 2) transfer between keyworkers
(3 1 2 2 3) comparative workloads
(3 1 2 2 4) gender and race
(3 1 2 2 5) group pressure
(3 1 2 2 6) ceiling of resistance
(3 1 2 2 6 1) personality disorder

(3 1 3) Etiquette

(3 1 3 1)acceptance of medical power
(3 1 3 2)not directly challenge
(3 1 3 3)advertise workload
(3 1 3 4)attend meetings
(3 1 3 5)scapegoat consultant
(3 1 3 6)conform to expectations
(3 1 3 7)mutuality

(3 1 4) Team punishers

(3 1 4 1) collegial disapproval
(3 1 4 1 2) sarcasm
(3 1 4 1 2 3) character assassination
(3 1 4 1 2 3 4) scapegoat
(3 1 4 2) humiliation in team
(3 1 4 3) personal sense of guilt
(3 1 4 4) isolated

(3 1 5) Team tensions

(3 1 5 1) comparative workload
(3 1 5 1 1) communication amongst team members
(3 1 5 1 2) caseload distribution
(3 1 5 1 3) offloading work onto others
(3 1 5 1 4) sense of competition
(3 1 5 2) multi-disciplinary philosophy
(3 1 5 2 1) perspective on care
(3 1 5 2 2) social workers' organisational autonomy
(3 1 5 2 3) dual identities
(3 1 5 2 4) lack of clear operating procedures
(3 1 5 3) authority
(3 1 5 3 1) consultant power
(3 1 5 3 1 1) association with

	management (3 1 5 3 1 1 1) clinical independence (3 1 5 3 1 1 1 1)staff leaving (3 1 5 3 2) leadership uncertainties **(3 1 6)Team support of the individual** (3 1 6 1) sense of belonging (3 1 6 2) source of clinical support (3 1 6 2 1) sharing risk
Framework 7 **(3 2) Managing boundaries**	
(3 2 1)Pressure on boundaries (3 2 1 1) service power differentials (3 2 1 2) default displacement (3 2 1 2 1) CMHT repository for risk anxiety (3 2 1 2 2) clinical pressure transfer **(3 2 2)Defending boundaries** (3 2 2 1) appropriate and inappropriate use of resources (3 2 2 2) deferential deflection (3 2 2 3) maintaining good relationships (3 2 2 4) need to define CMHT practice boundary (3 2 2 4 1) catchment area cognisance	

Management Charts

Framework 1 (2)Commissioning context	Framework 2 (3 1)Policy cognisance
(2 1)Commissioning structure (2 1 1) LA DHA joint commissioning (2 1 2) models of GP purchasing **(2 2)Contracting process and tensions** (2 2 1) commissioning intentions (2 2 1 1)too many priorities (2 2 1 2)GP commissioning intentions (2 2 1 2 2) financial signficance of GPs (2 2 1 2 2 1) threat of contract removal (2 2 1 2 2 2) comparative cost consciousness (2 2 1 2 3) GPFH influence on service (2 2 1 2 3 1) CMHT service alignment (2 2 1 2 3 1 1) improved communication (2 2 1 2 3 1 1 1) inappropriate information giving (2 2 1 2 3 2) requiring particular levels of service (2 2 1 2 3 3) diverting from SMI priority (2 2 1 2 3 3 1) GP referral to CMHT (2 2 1 2 3 3 1 1) risk contingency (2 2 1 2 3 3 1 2) CMHT response times (2 2 1 2 3 3 1 3) clinical independence from CMHT (2 2 1 2 3 4) drive down costs (2 2 1 2 3 5) envy of influence (2 2 1 3) competitive environment (2 2 2) negotiations (2 2 2 1) external relations (2 2 2 2)GPs (2 2 3) short-term agreement (2 2 4) fractured relationships (2 2 4 1) ECR costs (2 2 5) communicating to CMHT **(2 3)Resource pressures** (2 3 1) insufficient central government grant (2 3 2) purchasing intentions (2 3 3) statutory duty to balance budget (2 3 4) cost effectiveness and need projection (2 3 5) end of transitional funding (2 3 6) ECRs (2 3 7) level of MDOs (2 3 7 1) throughput and aftercare (2 3 8) specialist service use (2 3 8 1) need to maintain specialist services (2 3 9) loss of income (2 3 10) capital in buildings (2 3 10 1) re-configuring three trusts	**(3 1 1)Policies** (3 1 1 1) HoNoS (3 1 1 2) CPA (3 1 1 3) SMI (3 1 1 4) Supervision Register (3 1 1 5) Supervised Discharge (3 1 1 6) Patients' Charter (3 1 1 7) Clinical Audit (3 1 1 8) Primary Care (3 1 1 9) Locality Commissioning (3 1 1 10) Joint Working (3 1 1 11) Clinical team leadership (3 1 1 12) Local resource constraints (3 1 1 13) Strategic Plan **(3 1 2)Expressed opinions** (3 1 2 1) prescriptiveness (3 1 2 2) containment and supervision (3 1 2 3) insufficient resources (3 1 2 4) ambiguous and contradictory (3 1 2 5) politicised care (3 1 2 6) public confidence (3 1 2 7) need to better integrate services (3 1 2 8) uncertainty about impact on Trust (3 1 2 9) potentially will improve services (3 1 2 10) fait accompli (3 1 2 11) wasteful

(2 3 11) loss of capital savings (2 3 12) boundary responsibilities **(2 4) Responses** (2 4 1) cost effectiveness (2 4 2) defining target groups (2 4 3) cautious service reconfiguring (2 4 4) limiting referrals (2 4 4 1)signficance of ECR to Trust (2 4 4 2) specialist services (2 4 4 3) suggesting alternative clinical management (2 4 5) freezing in-patient closure (2 4 6) CMHT gatekeeping (2 4 6 1)SMI priority (2 4 6 2) deflection (2 4 7) services to absorb own pressures (2 4 7 1) reductions in service	
Framework 3 **(3 2)Embedded relations**	**Framework 4** **(3 3)Environmental influences on implementation**
(3 2 1) Symbiotic contacts (3 2 1 3) joint management **(3 2 2) Dependency** (3 2 2 1)Information dependency (3 2 2 2)implementation dependency (3 2 2 3)service dependency **(3 2 3) Identification** **(3 2 4) Informal and formal communicating on implementation**	**(3 3 1) External reporting of incidents** **(3 3 2) Complaints** **(3 3 3) Internalisation of government expectations** (3 3 3 1) consciousness of political accountability **(3 3 4) Comparative with range of problems** **(3 3 5) National politics** **(3 3 6) Influence of clinical director** **(3 3 7) Managing perceptions** (3 3 7 1)Public pressure

Framework 5 (3 4) Affective climate	Framework 6 (3 5) Implementation heuristics
(3 4 1) Blame culture **(3 4 2) Pace of change** **(3 4 3) Fear of being disciplined** (3 4 3 1) accountability **(3 4 4) Insecurity of employment** **(3 4 5) Scapegoated** (3 4 5 1) management responsibility for whole organisation **(3 4 6) Management clinician tensions** (3 4 6 1) constraining autonomy (3 4 6 1 1) clinical team leadership (3 4 6 1 2)interfering with discretion (3 4 6 1 3)inter-professional dynamics (3 4 6 2) information demands (3 4 6 3) increasing caseloads (3 4 6 4) cutting services (3 4 6 5) managers lack clinical credibility **(3 4 7) Inter-management tensions** **(3 4 8)Shared tensions** (3 4 8 1) poor consultation (3 4 8 2) too much bureaucracy (3 4 8 3) joint working (3 4 8 3 1) remit boundaries (3 4 8 3 2) information systems (3 4 8 3 3) locating identity (3 4 8 3 4) liaison (3 4 8 4) GP fundholding **(3 4 9)CMHT Implementation resistance** (3 4 9 1) resistance strategies (3 4 9 1 1) not record data (3 4 9 1 2) insistence on working within professional boundaries (3 4 9 1 3) not attending meetings (3 4 9 1 4) voicing negative views (3 4 9 1 5) using clinical autonomy (3 4 9 1 5 1) token compliance (3 4 9 1 6) not volunteering information (3 4 9 1 7) not volunteer to train (3 4 9 1 8) following guidance to the letter (3 4 9 2) collusive ambivalence **(3 4 10) competing pressures**	**(3 5 1) Risk cognisance** (3 5 1 1) conduct (3 5 1 2) defensive contingency (3 5 1 3) risk capacity (3 5 1 4) correct processes **(3 5 2) Criterion of virtue** (3 5 2 1) utility (3 5 2 2) equity (3 5 2 3) uniformity (3 5 2 4) explicitness (3 5 2 4 1) setting priorities (3 5 2 4 2) valuing accuracy (3 5 2 4 3) verify and demonstrate (3 5 2 4 4) clear accountability **(3 5 3) Stewardship of resources** (3 5 3 1) prioritise in relation to capacity (3 5 3 2) abhor waste (3 5 3 3) conserve (3 5 3 4) justify expenditure (3 5 3 5) opportunity cost consciousness (3 5 3 6) proactive management (3 5 3 7) accountability **(3 5 4) Discriminate in implementation** (3 5 4 1) rely on clinical autonomy (3 5 4 2) adaptation (3 5 4 3) correct processes (3 5 4 4) selective focus

APPENDIX I

Example of interview entered into QSR Nudist 4 and coding

+++ ON-LINE DOCUMENT: CON1

+++ Document Header:

*CONSULTANT 1

*CMHT A

++ Coded at 83 nodes.

(1 1 1) /CASES/WBCMHT/Con1

(2 1 1) /Implementing policy/Trust and Operational management interface/Trust management distance

(2 1 1 2) /Implementing policy/Trust and Operational management interface/Trust management distance/managerial distance

(2 1 2 1 1) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/Agent of policy/opm is a conduit

(2 1 2 2 1) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/non-empathic capacity/good relations

(2 1 2 3 1 1) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/Communication/communication avenues/professional discipline meetings

(2 1 2 3 1 2) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/Communication/communication avenues/internal media

(2 1 2 3 2) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/Communication/Resentment of informatics

(2 1 2 3 2 1) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/Communication/Resentment of informatics /information filtering

(2 1 2 3 2 2) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/Communication/Resentment of informatics /burdensome information giving

(2 1 2 3 2 6) /Implementing policy/Trust and Operational management interface/Operational 'capacity'/Communication/Resentment of informatics /top down communication

(2 2 1) /Implementing policy/Policy Cognisance/Policy legitimacy

(2 2 1 1) /Implementing policy/Policy Cognisance/Policy legitimacy/protects remit

(2 2 1 2) /Implementing policy/Policy Cognisance/Policy legitimacy/level of interface distance

(2 2 1 3) /Implementing policy/Policy Cognisance/Policy legitimacy/sympathetic to practice

(2 2 2 1) /Implementing policy/Policy Cognisance/Policies mentioned/focus on SMI

(2 2 2 2) /Implementing policy/Policy Cognisance/Policies mentioned/statutory policy

(2 2 2 3) /Implementing policy/Policy Cognisance/Policies mentioned/joint working

(2 2 2 5) /Implementing policy/Policy Cognisance/Policies mentioned/long term case register

(2 2 2 6) /Implementing policy/Policy Cognisance/Policies mentioned/consultant as team leader

(2 2 2 7) /Implementing policy/Policy Cognisance/Policies mentioned/meeting purchasers' needs

(2 2 3 1) /Implementing policy/Policy Cognisance/Expressed opinions/politicisation of mental health

(2 2 3 1 1) /Implementing policy/Policy Cognisance/Expressed opinions/politicisation of mental health/allaying public fear

(2 2 3 1 1 2) /Implementing policy/Policy Cognisance/Expressed opinions/politicisation of mental health/allaying public fear/prevent disasters

(2 2 3 2) /Implementing policy/Policy Cognisance/Expressed opinions/rationing resources

(2 2 3 4) /Implementing policy/Policy Cognisance/Expressed opinions/lacks specificity

(2 2 3 7) /Implementing policy/Policy Cognisance/Expressed opinions/policy is imposed

(2 2 3 9) /Implementing policy/Policy Cognisance/Expressed opinions/not helpful

(2 2 3 11) /Implementing policy/Policy Cognisance/Expressed opinions/management right to manage

(2 3 1) /Implementing policy/Implementation /Implementation dissonance

(2 3 1 3) /Implementing policy/Implementation /Implementation dissonance/clinical indisposition

(2 3 1 4) /Implementing policy/Implementation /Implementation dissonance/implementation sabotage

(2 3 2) /Implementing policy/Implementation /Implementation displacement

(2 3 2 1) /Implementing policy/Implementation /Implementation displacement/permissiveness not to provide a service

(2 3 2 2) /Implementing policy/Implementation /Implementation displacement/dilution

(2 3 2 3) /Implementing policy/Implementation /Implementation displacement/brokerage

(2 3 3 1) /Implementing policy/Implementation /Implementation cognition/Economic Man

(2 3 3 1 2 2) /Implementing policy/Implementation /Implementation cognition/Economic Man/Need to steward resources in clinical practice/cost consciousness

(2 3 3 1 2 3) /Implementing policy/Implementation /Implementation cognition/Economic Man/Need to steward resources in clinical practice/priorities

(2 3 3 2) /Implementing policy/Implementation /Implementation cognition/Risk cognisance

(2 3 3 2 1 1) /Implementing policy/Implementation /Implementation cognition/Risk cognisance/Community risk/forensic danger

(2 3 3 2 1 3) /Implementing policy/Implementation /Implementation cognition/Risk cognisance/Community risk/risk assessment

(2 3 3 2 1 4) /Implementing policy/Implementation /Implementation cognition/Risk cognisance/Community risk/deservingness

(2 3 3 2 2 1) /Implementing policy/Implementation /Implementation cognition/Risk cognisance/Managing risk to self/Adequacy

(2 3 3 2 2 1 1) /Implementing policy/Implementation /Implementation cognition/Risk cognisance/Managing risk to self/Adequacy/contingent risk response

(2 3 3 2 5 2) /Implementing policy/Implementation /Implementation cognition/Risk cognisance/Rigour of emphasis/risk contingency

(2 3 3 3) /Implementing policy/Implementation /Implementation cognition/Affective response

(2 3 3 3 1) /Implementing policy/Implementation /Implementation cognition/Affective response/thankless work

(2 3 3 3 2) /Implementing policy/Implementation /Implementation cognition/Affective response/the 'fallguy' double bind

(2 3 3 3 4) /Implementing policy/Implementation /Implementation cognition/Affective response/professionally devalued

(2 3 3 3 5) /Implementing policy/Implementation /Implementation cognition/Affective response/GP power

(2 3 3 3 6) /Implementing policy/Implementation /Implementation cognition/Affective response/controlled by immediate workload

(3 1 1 2 1) /CMHT Milieu/"Living inside the team"/Affiliation and role/Shared Constructions/Regulatory

(3 1 1 2 1 1) /CMHT Milieu/"Living inside the team"/Affiliation and role/Shared Constructions/Regulatory/pre-emptive assessment

(3 1 1 2 1 2) /CMHT Milieu/"Living inside the team"/Affiliation and role/Shared Constructions/Regulatory/statutory consciousness

(3 1 1 2 1 3) /CMHT Milieu/"Living inside the team"/Affiliation and role/Shared Constructions/Regulatory/maintenance of SMI

(3 1 1 3 1 1) /CMHT Milieu/"Living inside the team"/Affiliation and role/Distinct constructions/medical - leadership and expertise/ CMHT leadership

(3 1 1 4 3) /CMHT Milieu/"Living inside the team"/Affiliation and role/Professional identification points/contingent identities

(3 1 1 4 4 1) /CMHT Milieu/"Living inside the team"/Affiliation and role/Professional identification points/Reporting relationships/professional management

(3 1 1 4 4 2) /CMHT Milieu/"Living inside the team"/Affiliation and role/Professional identification points/Reporting relationships/general management

(3 1 1 4 4 3) /CMHT Milieu/"Living inside the team"/Affiliation and role/Professional identification points/Reporting relationships/clinical team leader

(3 1 2 1 1 1) /CMHT Milieu/"Living inside the team"/workload and distribution/size and nature caseload/nature of case load work/Schizophrenia

(3 1 2 1 1 7) /CMHT Milieu/"Living inside the team"/workload and distribution/size and nature caseload/nature of case load work/substance abuse

(3 1 2 2 1) /CMHT Milieu/"Living inside the team"/workload and distribution/allocative routines/consensual volunteerism

(3 1 2 2 6 1) /CMHT Milieu/"Living inside the team"/workload and distribution/allocative routines/ceiling of resistance/personality disorder

(3 1 3 1) /CMHT Milieu/"Living inside the team"/etiquette - conform and advertise/acceptance of medical power

(3 1 3 7) /CMHT Milieu/"Living inside the team"/etiquette - conform and advertise/mutuality

(3 1 5 1) /CMHT Milieu/"Living inside the team"/team tensions/comparative workload

(3 1 5 1 2) /CMHT Milieu/"Living inside the team"/team tensions/comparative workload/caseload distribution

(3 1 5 3) /CMHT Milieu/"Living inside the team"/team tensions/Authority

(3 1 5 3 1) /CMHT Milieu/"Living inside the team"/team tensions/Authority/consultant power

(3 1 5 3 1 1 1) /CMHT Milieu/"Living inside the team"/team tensions/Authority/consultant power/association with management/clinical independence

(3 2 1 2 1) /CMHT Milieu/Managing boundaries/Pressure on boundaries/Default displacement/repository for risk anxiety

(3 2 1 2 2) /CMHT Milieu/Managing boundaries/Pressure on boundaries/Default displacement/clinical pressure transfer

(3 2 2 1) /CMHT Milieu/Managing boundaries/Defending boundaries/Appropriate and inappropriate use of resources

(3 2 2 2) /CMHT Milieu/Managing boundaries/Defending boundaries/deferential deflection

(3 2 2 3) /CMHT Milieu/Managing boundaries/Defending boundaries/maintaining good relationships

(3 2 2 4) /CMHT Milieu/Managing boundaries/Defending boundaries/need to define CMHT practice boundary

Q.S.R. NUD.IST Power version, revision 4.0.
INTERVIEW: CMHT A, Consultant Psychiatrist 1
++
+++
Selected nodes coding none of document Con1:
(2 1 3) /Implementing policy/Trust and Operational management interface/financially led service restrictions
(2 2 3) /Implementing policy/Policy Cognisance/Expressed opinions
(3 1 4) /CMHT Milieu/"Living inside the team"/team punishers - being 'cast out'
(3 1 6) /CMHT Milieu/"Living inside the team"/Team support of the individual

Margin coding keys for selected nodes in document Con1:
A: (2 1 1) management interface/Trust management distance H: (3 1 1) ~"Living inside the team"/Affiliation and role
B: (2 1 2) ~l management interface/Operational 'capacity' I: (3 1 2) ~ng inside the team"/workload and distribution
C: (2 2 1) ~ng policy/Policy Cognisance/Policy legitimacy J: (3 1 3) ~e the team"/etiquette - conform and advertise
D: (2 2 2) ~g policy/Policy Cognisance/Policies mentioned K: (3 1 5) ~Milieu/"Living inside the team"/team tensions
E: (2 3 1) ~icy/Implementation /Implementation dissonance L: (3 2 1) ~eu/Managing boundaries/Pressure on boundaries
F: (2 3 2) ~y/Implementation /Implementation displacement M: (3 2 2) ~lieu/Managing boundaries/Defending boundaries
G: (2 3 3) ~licy/Implementation /Implementation cognition

+++ ON-LINE DOCUMENT: Con1
+++ Document Header:
*CONSULTANT
CMHT A
+++ Retrieval for this document: 300 units out of 300, = 100%
++ Text units 1-300:

Q
OK, XXXX, if we could just start off by you just telling me a little bit about your current position and the responsibilities that that involves. 5

*CON1: 6

Er, right. Well I'm a consultant psychiatrist at Pathfinder NHS Trust. I have responsibility for an adult catchment area of approximately forty-five thousand, which is defined by alignment with ten General Practices. I have responsibility for the community team, also the in-patient beds and the Day Hospital. 7 H

*Q: 8

And, in terms of responsibility, how do you define that term in relation to what you've just said? 9

*CON1: 10

Well, I would have the medical responsibility for any adult psychiatric problems arising from within my defined population. There's also sometimes boundary issues with highly specialist services, adolescent services, but essentially the remit is with the adult population although H L M

clearly, that's not particularly well defined, so there are areas of grey in that. 11 H L M H L M

*Q: 12

OK. In terms of the other members of the team, how would you define your responsibility ? 13

*CON1: 14

Well, there have been some recent changes with the concept of 'clinical team leadership', although that's not particularly well-defined. So, essentially, each individual profession clearly has their own professional responsibilities and accountability. So I would have the medical responsibility, 15 A D H J A D H J A D H J A D H J

* 16

but not ... and so would have some general responsibilities in overseeing the provision of service, but clearly, if someone within the team acts in a professionally irresponsible manner, that would essentially be dealt with through their line management rather than by myself. Although I would have, I think, some responsibilities in identifying those sorts of problems if they occurred. 17 H H H H H H H

*Q: 18

Right, OK. Can I just explore the relationship between yourself as a team leader and the operational management side. Are there any issues, which you feel exist in relation to those two types of responsibility? 19

*CON1: 20

To a certain extent, too, I think my relationship for example with XXXis in some ways mirrored by XXXXXXXXX' clinically directed relationship with XXXXXXXXXXXXXXXXX as adult service manager. So I think in many ways, decisions are taken at that level and driven down to me through Tom and to XXXvia Carrie. So I think that - (sighs) there aren't an enormous number of difficulties. 21 H H H H H H H

* 22

I think that if difficulties arise with my relationship with Sue, they tend to be, in fact, because of a focus elsewhere rather than between ourselves. 23 A A A

*Q: 24

Right. So If I could summarise that, then, if there are any issues that arise, it's actually other people's agendas being played out through you and Sue, is that how you're seeing it ? 25

*CON1: 26

Yes I think so. For example, if Sue, for example, were to turn up and say: 'All routine referrals have to be seen within two weeks', I think B H B H

clearly we would find that hard to deal with. But I think that, in many ways, that would have been agreed by Carrie and Tom. So clearly, XXX would be the sort of messenger, really. So I think I would try and address those difficulties with Tom rather than with Sue. 27

*

My dealings with XXXare much more on a sort of a... She's a sort of a trouble-shooter. So, if there are particular problems with getting patients admitted or other issues -(bleep interrupts) I can't remember where we were ! 29

*Q:

Right, you were talking about your relationship with Sue. 31

*CON1:

Oh yes. Clearly there are sort of... She deals with practical day-to-day issues. I don't think we have an enormous amount of conflict with her. 33

*Q:

OK. I'd like to look at, now, some of the local issues that you feel are having a particular impact, both on your work as the consultant and on the wider work of the team as a whole. 35

*CON1:

Right. I think the key isXXXat the moment, really, is the contraction of the highly specialist services. I think they are clearly having funding difficulties and trying to define their... They're defining their boundaries more clearly. 37

*

I think what's happening at the moment is with our population is being 'defined by default' as it were: 'If you don't have an eating disorder, you must belong to the CMHT.' 39

*

I think the other issue, what is happening is, for example, a recent paper sent around by the Mother and Baby service, with quite a long list of expectations on the CMHT for someone who's admitted to Mother and Baby. It seems as though Mother and Baby are not able to provide an outreach service within their existing resources. But rather than put their prices up, which is clearly unacceptable at the moment, they're trying to get round that by essentially poaching our services. 41

*

So I think that the key isXXXfor us is trying to protect our boundaries really. 43

*Q:

And in what form does that protection take? How do you go about protecting your boundaries ? 45

*CON1: 46

Well, I think that what we must do is take the lead from the highly specialist services and clearly define what is the remit of a CMHT. I think at the moment, there is this problem that we are defined by default. I think we have to have a clearer idea about what is a suitable case for a CMHT to take on. 47

*Q: 48

Is that work ongoing at the moment, do you think? 49

*CON1: 50

Yes I think it is to a certain extent. I think that's certainly a repeated discussion point with the adult consultants. 51

*Q: 52

Right, OK. That leads me on to two things. One, first of all, is the isXXXabout the resources.You say that the team is being defined by default. In relation to the resources and what you were saying, how can you resist that? If, for example, no-one is going to get an anorexic service, it seems that it would be natural therefore, for you to take up that. 53

*CON1: 54

Well. I don't think it is. I think the thing is that, at the moment, the purchasers for example want it both ways. If, for example, they can only afford to fund twenty people with anorexia within Wandsworth for a year, that's fine. But when you get to the twenty-first person, I think you have to say: 'Well, we can't pay for any more'. At the moment, they're not saying that. What they're saying is that the expectation that CMHT will absorb that. 55

*

I think we have to be saying - Because, at the moment, what's actually happening, as I mentioned before is that if you don't fit into the Forensic service, you must fit into the CMHT service. Now that doesn't actually follow. It may be that if the Forensic service aren't able to provide you for a service, no-one can. It should be said: 'Well, we can't'. Maybe Forensic is not a particularly good example, but I think there are. I think what we have to say is that some people can't be looked after because of funding issues and that's the way it's going to have to be, really. I think the problem for us is that we seem to be an ever-expanding caseload and varied caseload, we're not really geared up to provide. 57

*Q: 58

In relation, then, to the commissioners who, at the end of the day, are driving this agenda, to what degree do you have a strong position to be able to say that to them, as they're the people who are going to be purchasing your service ? 59

*CON1: 60

I think that is difficult and clearly at my level, we don't have an enormous say in that. It will have to go up through the clinical directorates. But I think that is the isXXXfor us, but I think it is quite hard to - 61

* 62

Although... I think it may be... The other end of the spectrum is that GPs are putting increasing pressure on us to provide counselling at the less psychotic end of the spectrum, as it were. It may be that we'll have to draw up our boundaries and say: 'Well, we can't provide these services'. At the moment, although we have a remit to provide care for the seriously mentally ill, long-term mentally ill, this isXXXof saying 'No' to the GPs is done on a bit of an ad hoc basis at the moment. 63

* 64

If we're getting increasing pressure to deal with the highly specialist services end of the spectrum, we'll need to perhaps draw our boundaries at the bottom. 65

*Q: 66

I'd like to come back to the GPs in a minute and I'd like to explore what you've just said then. Before I do that, there are two areas that I'd like to explore with you particularly in your role as a consultant. The first of these, as you're well aware, recruitment vis a vis psychiatric consultants is down and is an issue. From your perspective, why can we not recruit consultant psychiatrists? 67

*CON1: 68

Well I don't think it's an enormously attractive job really, at the moment. I think the rewards, both extrinsic and intrinsic are not particularly high. I think there are particular concerns and difficulties within inner-city areas, where the demands are higher. 69

* 70

I think, in some way, some of the extrinsic rewards, like private practice, are less available. I think there is this feeling that increasingly, one of the attractions of being a consultant is the autonomy that one had and enjoyed. I think that's increasingly, clearly, going, to a certain extent in a, probably, a positive way. There aren't an enormous number of things, which commend it at the moment. I think that's why it's hard to recruit. 71

*Q: 72

OK. You mentioned in particular, recruitment vis a vis the inner cities. What are the particular issues there that you think operate ? 73

*CON1: 74

Well, I think clearly, the workload is higher. There clearly is a higher workload. I think there is more violence. There's more drugs. There's less family structure and so in some way, there's less scope for working with people, working with their families. In some ways, it's much more a crisis intervention - type service. There's less chance to get positive feedback, really. 75 G I

*Q: 76

Yes. You also mentioned the curbs on autonomy. From your own personal experience, how is that operated? 77

*CON1: 78

I think it just is. We're increasingly being driven by external pressures. You know, government pressures. I mean the CPA, which is probably a good innovation , but things like 'supervised discharge', 'supervision register', I think are less... I've got a book of an enquiry on my desk. I think clearly there were difficulties there. 79 D H

*

I just think one feels there are more demands on one and I think the purchasers and the GP fundholders are putting increasing demands on us. I think one feels that sometimes the people who don't have a good understanding of mental health are in fact driving the agenda. 81 A D G

*Q: 82

Right. Let me just clarify that then. Are you saying that the environment in which you're having to practice is essentially being shaped by other people, such as public perceptions, and that in a way, you're being affected in the same way that perhaps other people's perceptions are affected by that environment? Or are you getting specific policies, guidelines, orders, for want of a better word on particularly what to do? 83

*CON1: 84

I think it's... I think at the moment, we're not getting an enormous number of things telling us specifically what to do. I think at the moment, some of those are by consensus. But I think what's happened is that mental health is becoming an increasingly political specialty, really and I think that a lot of the particular things we have concerns about are driven by wider political concerns, actually. 85

*Q: 86

Right. So it's about actually having a fear about the potential of what would happen if things go wrong. Would that be fair to say ? 87

*CON1: 88

I think there's very little recognition , 'cause it's not politically G
expedient to recognise that, but things inevitably go wrong in mental G
health. Even with the best procedures, things do go wrong. 89 G

* 90 G

I think that when something happens and individual cases are subject to G
scrutiny, it's impossible to provide perfect care for everyone. I think G
what happens is, when individual cases are subject to scrutiny, one is G
pilloried, and it's said: 'Ooh, this was terrible', and I think it's not G
a particularly realistic understanding of the complexities and the G
difficulties in dealing with mental health, really. 91 G

*Q: 92

So how does that affect yours and the team's practice prorites? 93

*CON1: 94

Well, I think we've prioritised people we feel are going to hurt someone G
else, initially. That's the key and then secondly, people who we feel are G
going to hurt themselves. 95 G

*Q: 96

So - I've got a particular patient in mind, who's been a regular subject
of discussion - it seems from the discussions that the team have had,
he's not really what you might call 'ill', he's more of a rather nasty
character. ('patient X') Who has the potential to cause damage either via
his pornographic interests, or his behaviour. Is that the sort of person
you're thinking of ? 97

*CON1: 98

Not... I think the person you just mentioned has caused particular
concerns really because he just is so very troublesome and stirs up lots
of emotions on the ward, in the community team and outside. I think he's
someone who in some ways is a priority because his behaviour makes him a
priority. He's not someone, for example, I would have particular concerns
about, because I think he's probably unlikely to hurt someone else. Even
if he hurts himself, which is a more likely possibility, I feel that one
could defend what we've done. 99

* 100

I think people who particularly cause concern are people who have got a G
history of violence towards others, really. 101 G

*Q: 102

Right, OK. And that would be exclusive of their mental state, would it ? 103

*CON1: 104

Yes, yes. I think in some ways, people with psychosis who are a danger to G

others are much easier to deal with. It's clear where they fit. I think people with personality disorder who have a history of violence are more concerning. 105

*Q: 106

That just leads me on then, to ask what are your personal / professional concerns about what you're being asked to do? 107

*CON1: 108

I think the most frustrating thing is that people transfer their anxieties and responsibilities on to the team, and me in particular. So it's quite - Someone from, I don't know, a day centre, or housing will phone up and say: 'We think this person's violent or is going to do something. You must do something'. Now clearly, in one instance, that may be reasonable, but if you're personally aware that this person has done that twenty times in a year, it's quite exhausting. 109

*

110

You feel... But then again, there's always the possibility that one of those times it actually will happen. You can see people saying: 'Well, I phoned up and told them'. The fact that they told us about thirty other people would not be... I think the fact that people are particularly anxious about mental health, and feel that once they've essentially phoned us and said: 'We think this man's...Something needs to be done', they've in some ways, 'fired off' their responsibility. So it's then down to us. We're a bit left, then, not knowing quite what to do. 111

*Q: 112

And are there any particular policy initiatives from the previous government - I presume they're going to be carried on for a little while longer yet ! - or the local trust that cause you professional concern ? 113

*CON1: 114

Not so much actually, no. No, I don't think so. I think supervised discharge has not been a success. I think the supervision register is... of limited benefit, although it does at least identify people where one's concerned. 115

*Q: 116

Right, OK. Can I ask you now about GPs? 117

*CON1; 118

Right. 119

*Q: 120

One of the things that I've noticed in your referral meetings is that often, a letter will be preceded by the term 'urgent referral'. Are you finding that GPs are increasingly using that? 121

*CON1: 122

Yes, I think particular GPs, actually. That is one of the key problems for us, because at the moment, one of the things laid down by the trust is that urgent referrals need to be seen within a week. But there's actually no definition on 'urgent' and no expectation that GPs should use that responsibly. In some ways, that, again causes a problem for CMHTs. It's not as if we're saying: 'the average CMHT can respond to fifty urgent referrals a year' or something. In some ways, every GP could phone up and say that everyone is urgent. So I think that's actually a problem again. It's us actually being able to defend our boundaries. But yes, I think 'urgent referrals' do cause us problems, actually. 123

*Q: 124

In terms of that, presumably there's the trust response time that you have to bear in mind. Is there anything else in relation to that which would cause problems ? 125

*CON1: 126

No, I don't think so, but I think there is this sort of unspoken fear that the GP sends something and, right, it's got 'urgent' at the top. If you don't actually respond to it, clearly one would have difficulties defending one's action if something actually did happen. 127

*Q: 128

That leads me on then, to asking you how much you think that GPs are beginning to shape the way that you and the team work? 129

*CON1: 130

Not an enormous amount. I think... we've been aligned to our GPs must be for a couple of years now. I think in some ways, particularly with the good GPs, we're both learning from each other as to how we work. So in many ways, with most of the practices, we're actually sort of shaping each other really, I think. 131

*Q: 132

You mentioned earlier on about the fact that GPs want you to deal with the less psychotically ill, counselling and that sort of activity. Now, how much do you feel you have to respond to that? 133

*CON1: 134

Well, I think one has to respond in terms of at least doing assessments. 135

*Q: 136

Right, OK. 137

*CON1: 138

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I think if some people are referred in specifically, saying: 'This person needs counselling', I think occasionally we either send them back or send them on elsewhere. But I think often, they're not framed like that. They're framed like: 'I think this person may need counselling, please see and advise'. In some ways, it may be quite reasonable to see those people on a one-off basis. 139

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*Q: 140

OK. What are the main issues, then in relation to that particular client group not being seen by you, do you think? 143

*CON1: 144

Well, I think the GPs would feel very angry about that, really. 'Cause I think in many ways, those are the people that give them the most difficulty, in terms of repeated attendance, being quite demanding. I think the GPs would see that as a population they do want dealt with. 145

*Q: 146

And what prevents you from dealing with that population ? 147

*CON1: 148

Well, I think firstly, we don't necessarily have the skills to deal with them. At any one time, there are people in the team who have specific counselling skills. But that's not always the case. So I think we don't necessarily have the skills. Clearly, our priorities are elsewhere. 149

*Q: 150

Right, and they lie with...? 151

*CON1: 152

I think with assessment and treatment of people with more recognised mental disorder, really. Obviously, long-term mentally ill, but also people with depressive disorders, other psychological problems. 153

*Q: 154

How well-defined do you think they are ? For working purposes ? 155

*CON1: 156

They're not. I don't think they're well-defined at all, actually. 157

*Q: 158

Right. How do you feel that can be improved ? 159 D G M

*CON1: 160 D G M

Well, linking back on what we said before, I think we do need to have D G M
clear, written guidelines as to what things fall within the remit of a D G M
CMHT. 161 D G M

*Q: 162

OK.How do you reconcile that with the emphasis that you're being given by
the local commissioner to look after the group known as 'The Severe
Mentally Ill? 163

*CON1: 164

Well, I think we are, in some ways, fortunate that government policy does C D
dictate priorities with the long-term mentally ill. So I think in some C D
ways, it's not necessarily for us, particularly, to resolve, 'cause I C D
think that GPs can't just say to us: 'Well, we just want to purchase C D
counselling. We're not interested in people with schizophrenia', because C D
I think that clearly there are external Department of Health directives, C D
which stop them doing that. So I think at least in some ways, we do have C D
at least some external protection. 165 C D

* 166 D

But I'm not sure it's something that we're able to resolve. I think D G
that's presumably something that needs to be resolved by the purchasers. D G
I suppose the concern about whatever, whoever leads the various services, D G
is that who's going to take the strategic overview ? 167 D G

*Q: 168 D

How much pressure is on you in relation to ensuring that that GP D
fundholding income is maintained and expanded? 169 D

*CON1: 170 D

Well, I think for us, I think clearly there are some pressures on us to D M
ensure that our relationships with our fundholders are good. Certainly, D M
the fundholder within our patch we have good relationships with. I think D M
in some ways, a lot of the issues they raise are reasonable ones. In D M
fact, they're not with us, they're not with the CMHTs, they're with the D M
highly specialist services normally. 171 D M

* 172 D

I think in many ways, the issues that the GPs raise are the issues that D M
we have problems with the specialist services. In terms of them being D M
remote and rather precious and difficult and poorly communicative. In D M
many ways, I have quite a lot of sympathy with the fundholders. I feel D M
that probably, if we had that sort of clout that we would do the same. 173 D M

*Q: 174 D

Right, right. 175 D

*CON1: 176 D

And certainly, whenever I meet up with our fundholder, the complaints are predominantly around the highly specialist services rather than the CMHTs. So I think in some ways, CMHTs provide sort of a local service. It's quite hard to see how a fundholder in the middle of Battersea would purchase all their general adult services from somewhere else. I think they do have to be geographically close. 177 D M

*Q: 178 F M

Right, OK. If I can just summarise, then, and then explore with you the summary. - Essentially, what you're saying to me is that overall, your relationship with the GP practices is very good. 179 F M

*CON1: 180 F M

Yeah. 181 F M

*Q: 182 F M

They're not really dictating practice. 183 F M

*CON1: 184 F M

No. No, I don't think they are. 185 F M

*Q: 186 F M

And for a large number of that client group, what you are effectively becoming is more of an enabling agency, vis a vis that patient population. Would that be a fair...? 187 F M

*CON1: 188 F M

Enabling and screening, yes. 189 F M

*Q: 190 F

Do you feel that the trust and commissioners recognise that that's what you're actually doing? That you're actually screening and enabling rather than necessarily treating ? 191 F

*CON1: 192 F

Em... I don't know the answer to that, actually. I'm not sure. 193 F

*Q: 194

Right. OK. Is that, would you say that you're not sure because it's never been discussed or does that sort of information never get communicated to you? 195

*CON1: 196

No, it's not communicated. I have no idea what our purchasers think, A B D
actually. I've no real way of knowing. The only purchaser I have any A B D
dealings with is our fundholder and of course, I have some wider idea, A B D
but no. We have some information obviously via service managers and the A B D
clinical director, but I think that's quite filtered on sort of 'need to A B D
know' basis, fairly sort of biased. 197 A B D

*Q: 198

What issues do you think that lack of communication raises for you as
practitioners ? That lack of two-way dialogue? 199

*CON1: 200

(Sighs) Well, clearly, it needs to be improved. It may be that a lot of A
this discussion is going on and we're just not aware of it. But I think A
at grass-roots level, we feel a bit cut off from decision-making A
processes. 201 A

*Q: 202

Do you feel that the decision which are finally communicated to you are
affected by that lack of input? 203

*CON1: 204

Yes. Yes I think they are, actually. 205

*Q: 206

In what ways ? 207

*CON1: 208

Well, I think, clearly... It's easier to make decisions... Decisions that A C
people make when they don't have to implement the consequences of their A C
decisions are easier to make than... It's easier to say: 'Each CMHT has A C
got to see six hundred people a year' if you don't have to do it, really. A C
I think it is important to have people making decision who are actually A C
going to have to carry out the policy. 209 A C

*Q: 210

To make it work, yes. 211

*CON1: 212 C

I think that some of the policies which arise from Pathfinder, about A C
discharge, or care plans, or things obviously have had very little input A C
from people who are actually doing the work, actually. 213 A C

*Q: 214 C

So how does that affect the actual work, that lack of input? 215 C

*CON1: 216 C

I think it's quite exhausting, because policies arise which then have to be sent back for all sorts of reasons. It's quite an exhausting business. So it's time-consuming and clearly some of the policies we end up with are not tremendously good. 217 C E

*Q: 218

When you say "not tremendously good", how does that impact on your practice? 219

*CON1: 220

Well, some of the things don't get used. Supervised discharge is probably a good example. I think there was one person within Pathfinder on supervised discharge. I think it reflects that it's not a good policy. I think that the Care Programme audit that Mandy did showed that virtually all the standards were not being met. I think that's probably not because people are inefficient, but because the standards have very little meaning and influence on people's day-to-day lives. 221 C D E F H

*Q: 222

That leads me on then, to asking about information. What sort of information is the team required to provide, to either the trust or the commissioners ? 223

*CON1: 224 C

Well, that's changing. Clearly at the moment, there are things like Korner statistics, my out-patient contacts are recorded. Bed usage is recorded. So there's not - I don't have to do Korner and a lot of the other things are collected for me. So at the moment, I don't have to provide an enormous amount of information myself. Although, with the new information system, that will change. 225 C

*Q: How useful is the information? 226 B C D

*CON1: 227 B C D G

I think that's variable. There's things like the long-term case register, which I think is of no benefit whatsoever. I think that people feel very resentful about doing that, 'cause they see it has very little impact on their lives. So I think those sorts of things are not helpful. I think other things like contacts, I think people - although it's not a tremendously attractive task to do - I think people understand why it needs to be done. So they're probably willing to do it. 228 B C D G

*Q: 229 G

What's your understanding of why it needs to be done? 230 G

*CON1: 231 G

Well, I think it's essentially because people are asking more and more, in increasing detail, what they're spending their money on, really. 232 G G

*Q: 233

Right. What, if you were asked, would you do in terms of improving the sort of information that you're being asked to require? How would you change it? 234

*CON1: 235

Well, I think it needs to be less, but of better quality. I think at the moment, what the purchasers seem to want to know is just more and more and more detail. Now I can't possibly imagine that all that information is looked at, 'cos it must be - It must just generate enormous amounts of information. 236 B C D B C D B C D B C D

*Q: 237 B

Is there any mechanism by which the results of the information analysis are fed back to you? 238 B B

*CON1: 239 B

No, not in any coherent form, no. 240 B

*Q: 241

OK. So in terms of information being communicated to you and the team, how is that primarily done? 242

*CON1: 243

Well, it's very ad hoc. We get very little information, actually. As clinical team leader, I get a quarterly report about activity. Most of which is meaningless and impossible to understand. We get very little feedback on information, actually. 244 A B A B A B A B

*Q: 245

Have you or the team ever been asked to submit either proposals or comments on decisions or issues that the trust is having to struggle with? 246

*CON1: 247

No. Not in any - With occasional projects, there are meetings to launch the project or to take soundings, but that's on a pretty infrequent basis, actually. 248 A A A

*Q: 249

Right, OK. I just want to move on to one last area, which is the area of the team itself and how it operates. How, first of all, would you describe the way the team operates? 250

*CON1: 251

In terms of what? 252

*Q: 253

In terms of both it's dynamics and in terms of what it actually does. 254

*CON1: 255

Right... I suppose the way it works, I suppose we have a fairly flattened hierarchy. I don't think we have a sort of hierarchical decision-making process. But I think there is some hierarchy, 'cause I think it's not possible to function in any other way. I think there are occasional tensions. 256

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Inevitably, there will be, with any group of people. I think there are some sort of structural-type tensions, particularly between health and social services really, 'cause I think the management structures are different. I think there are occasionally, tensions between the two. 258

*Q: 259

How would you characterise the main area of those tensions ? What would you say were the things that most often raised those tensions? 260

*CON1: 261

Well, essentially, I think what's happening is that more and more, the social workers are being told by their line managers what they should be doing. I think that's clearly - More and more, they're being defined, which cases are 'social work'. 262

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I think, clearly, at the moment, the way the team works... the distribution of work is fairly free at the moment. But I think that's happening less and less. I think that in some ways, the social workers are tied in much more and more to picking up particular cases and types of cases. In some ways, that probably works to the advantage of the other members of the team. 'Cause for example, if someone's referred in with housing, I don't know, if ten people are referred in with housing one week, they all go to the social worker. So, in some ways, it's caused less of a problem for us, actually. I think it's probably caused more of a problem for the social workers. 264

*Q: 265

In terms of getting patients to comply with treatment, are things like the ability to have access to at least a housing waiting list and perhaps affect where that patient lies on it, are those things useful in terms of getting patients to comply? 266

*CON1: 267

Not fantastically, actually. I don't think so, no. I think, occasionally, it is possible to help people, so it is useful to a certain extent. But I think in terms of getting them to comply with treatment and follow-up, probably not actually. 268

*Q: 269

Right, OK. What would you say was the value of having social services within the team ? 270

*CON1: 271

Oh, I think it is a lot of value, mainly because so many of the issues, D
which arise in mental health are inter-agency. I think most of the D
problems are. So, most people with serious mental illness don't just have D
medical-type problems, they have accommodation and I think there's a D
complex interaction of those. I think things like mental health act D
assessments, Section 117, aftercare, planning, I think the whole move D
within mental health is to increase the integration. I think that having D
social workers in the team is probably the key factor, which makes the D
function of the team better. 272 D

*Q: 273

Just one last question, which is the sixty-four million dollar one ! 274

*CON1: 275

Right ! 276

*Q: 277

What are your views on the CMHT acting in a brokerage role? 278

*CON1: 279 F

I don't think that one would just want to go to a model where, F
essentially, you're just sort of brokering care without actually doing F
any of it. I think the prime role of the CMHT should be to provide care. F
But I think there would be a lot of scope for being able to purchase some F
of our services, actually. That would be very useful, I think. So, I F
think at the moment, as I keep bringing up, we are at the ...I think in F
some ways, our relation to some of the other services are what, F
presumably, GPs used to be like. So, I would say, refer someone off to F
Forensic and they say: 'No thanks'. I would actually quite like to hold F
the budget and say: 'We're going to be able to purchase twenty Forensic F
contacts a month, or whatever. We'll decide what those ones are going to F
be. Also, as purchasers, we would then have some expectations on you as F
providers as to what you're going to do'. 280 F

*Q: 281 F

So, in lots of areas, you feel that without that power, you're in quite a F
weak position ? 282 F

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APPENDIX J

A comparative of the strengths of the Trust as outlined in the 1995/1996 and 1996/1997 Business Plans

1996/ 97 Business Plan	1 995/96 Business Plan	Comments
Title of Section: Review of Current Position	**Title of Section:** The Opportunities and Threats We Face	Indicates a move to a more self-confident position having had trust status for a year.
Strengths	**Strengths**	
1. A growing reputation for the quality of our local services	A growing reputation for and recent acknowledgement of the strength of its local service	A promotional statement to potential purchasers and message to staff about quality importance.
2. A well established reputation for many specialist services	A well established reputation for many specialised services	As above.
3. A long standing, successful relationship with (GENERAL HOSPITAL NAME) Medical School, a source of expertise and innovation in treatment and care	A demonstrable capacity for service innovation	An emphasis on strength of local relationships and range of expertise which can be called upon to develop and support changes.
4. A demonstrable track record of putting the needs of seriously mentally ill people first	A demonstrable prioritisation of the needs of seriously mentally ill people	Use of the word "prioritisation" thereby putting greater emphasis on management's commitment to central policy priority.
5. A clear commitment to improving relationships and enhancing communication between General Practitioners and Trust clinicians	A clear culture of multi-disciplinary, multi-agency working	Highlighting the particular importance of GPs above other agencies
6. A growing capacity for using information and information technology to inform the management of clinical services	Not mentioned as a strength	Use of the phrase "growing capacity" implies a developmental expertise and skill. Mentioned as a weakness in 1995/1996
7.A well established and consistent senior management team with demonstrable clinician involvement	A consistent, well-informed senior management team	Highlights involvement of clinicians in management. Use of the term "consistent" casts insight of critique of government demands to reduce management costs as this is a threat to consistency .

Table 9.2(a)
A comparative of the weaknesses of the Trust as outlined in the 1995/1996 and 1996/1997 Business Plans

1996/ 97 Business Plan	1995/96 Business Plan	Comments
Weaknesses	**Weaknesses**	
8.High staff costs partly but not entirely attributable to our status as a teaching hospital	Not identified as a weakness	This statement appears to be in part a result of the criticism levelled at the Trust by a 1995 report for the Mental Health Task Force Project on the Case Study site which stated that there the staffing ratios within the Trust were very high and there was too high a ratio of qualified to unqualified staff. As such the statement's linking of staff costs to its status as a teaching hospital can be interpreted as a means of deflecting criticism.
9. A property in (TRUST HOSPITAL NAME) which suffers massive backlog maintenance and has many adverse features for the provision and development of mental health services	A property in (TRUST NAME HOSPITAL) which has many adverse features for the provision and development of mental health services	Change highlights not only the inadequacy of the Trust site but, by implication, the resource costs that would be incurred to improve it.
10. Insufficient development of evidence based outcome measures of service quality	Not mentioned i	An indicator on the shifting emphasis of Government towards evidence based practice. May also indicate a cultural shift consequent of purchasers demands that they receive evidence as to the effectiveness of what they pay for .
11.A culture which does not yet sufficiently affirm strengths over deficiencies and commitment across all staff groups to service and corporate objectives	A very wide range of services with complex staff groups who have different allegiances	Indicator of the poor morale/ engagement of staff with management and management objectives.
12.A brand name for (TRUST'S NAME) specialist mental health services associated with (GENERAL HOSPITAL'S NAME) which is not part of the Trust	A brand name for (TRUST'S NAME) specialist mental health services associated with (GENERAL HOSPITAL'S NAME) which is not part of the Trust	Somewhat contradicts statements 1;2 & 3 above.
13. Poor past investment in information systems and technology	Poor clinical information systems	An implication that deficiencies of 1995/96 are being addressed, particularly with reference to 6 above.
14. A perceived communication weaknesses internally and externally – (TRUST'S NAME) is not well known and understood in the local community	Insufficiently strong links with primary care and hence a mixed reputation with general practitioners	Apparently contradicts 1 & 5 above.

Table 9.2(b)
A comparative of the strengths of the Trust as outlined in the 1995/1996 and 1996/1997 Business Plans